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ABSTRACT

This summary of legislation, with a special focus on maternal and child health and primary care, describes nearly 600 laws and resolutions pertinent to these issues passed by the 50 states, the District of Columbia, and Puerto Rico in the 1996 legislative sessions. The summary includes health care reform and access issues, managed care and insurance reform, and 23 other topics that involve the health status of women, children, minorities, and rural school and special health needs. Key words are underlined to assist the reader in identifying legislation about specific issues. Several acts are referenced in more than one section of the publication. Following an executive summary, descriptions of legislation are grouped into 27 categories. There is also a state-by-state summary of legislation. (Arkansas, Montana, Nevada, North Dakota, Oregon, and Texas did not hold regular sessions in 1996.) Previous editions of this publication included an adolescent health section and a more comprehensive school-based health section; the National Conference of State Legislature's (NCSL's) publication "Adolescent Health Issues: State Actions 1996" now covers those topics. (EV)

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Health Care Legislation 1996

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HEALTH CARE LEGISLATION 1996

BY
THE NCSL HEALTH CARE PROGRAM

NATIONAL CONFERENCE OF STATE LEGISLATURES
WILLIAM T. POUND, EXECUTIVE DIRECTOR

1560 BROADWAY, SUITE 700
DENVER, COLORADO 80202

444 NORTH CAPITOL STREET, N.W., SUITE 515
WASHINGTON, D.C. 20001

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The National Conference of State Legislatures serves the legislators and staffs of the nation's 50 states, its commonwealths and territories. NCSL is a bipartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures,
- To foster interstate communication and cooperation, and
- To ensure states a strong, cohesive voice in the federal system.

The Conference has an office in Denver, Colorado, and Washington, D.C.

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PREFACE AND ACKNOWLEDGMENTS

Health Care Legislation 1996: With a Special Focus on Maternal and Child Health and Primary Care summarizes nearly 600 laws and resolutions pertinent to maternal and child health and primary health care issues passed by the 50 states, the District of Columbia and Puerto Rico in the 1996 legislative sessions. It includes health care reform and access issues, managed care and insurance reform and 23 other topics that involve the health status of women, children and others. Key words are underlined to assist the reader in identifying legislation about specific issues. Arkansas, Montana, Nevada, North Dakota, Oregon and Texas did not hold regular sessions in 1996. Several acts are referenced in more than one section of the publication.

Previous editions of this publication included an adolescent health section and a more comprehensive school-based health section. NCSL's publication, *Adolescent Health Issues: State Actions 1996*, now covers those topics.

This publication was made possible by projects MCU-0860045 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, U.S. Department of Health and Human Services and CSU-080004-01-1 from the Bureau of Primary Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

NCSL is indebted to many state legislative staff who identified relevant legislation and sent copies of acts. NCSL staff relied heavily on legislative summaries produced by state legislative research agencies in producing this publication. NCSL also used summaries produced by its Health Policy Tracking Service.

Tasha Morton was responsible for word processing, organization and layout. The authors greatly appreciate her assistance. (She had an especially challenging assignment because of numerous computer problems.)

We apologize for information inadvertently omitted and for any errors. NCSL appreciates being notified about mistakes. If you have suggestions or requests for further information, please call or write NCSL's Health Program staff in the Denver office, (303) 830-2200.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
AFDC	Aid to Families with Dependent Children
APRN	Advanced practice registered nurse
COBRA	Consolidated Omnibus Budget Reconciliation Act, which protects employees who leave a job by allowing them to continue to purchase health insurance
CPR	Cardiopulmonary resuscitation
DPT or **DTP**	Diphtheria, tetanus, pertussis (whooping cough) vaccine
EPSDT	Medicaid's Early Periodic Screening, Diagnostic and Treatment Program
ERISA	The federal Employee Retirement Income Security Act of 1974
FPL	Federal poverty level, which was $12,980 for a family of three and $15,600 for a family of four in 1996
FY	Fiscal year
Hep B	Hepatitis B vaccine
Hib	Haemophilus influenza type b (for meningitis) vaccine
HIV	Human Immunodeficiency virus, which causes AIDS
HMO	Health maintenance organization
MMR	Measles, mumps, rubella (German measles) vaccine
PKU	Phenylketonuria, a genetic condition that can cause mental retardation
PPO	Preferred provider organization
SIDS	Sudden infant death syndrome
TBI	Traumatic brain injury
WIC	The federal Special Supplemental Food Program for Women, Infants and Children

EXECUTIVE SUMMARY

Nearly 600 laws and resolutions pertinent to maternal and child health and primary health care issues were passed during 1996 state legislative sessions. Many of the laws summarized in this document also relate to health issues for the general population as well, especially those contained in the access and reform, finance, insurance and managed care, and provider sections. Highlights of the legislation are summarized here by topic. The pharmaceuticals, rural health and telemedicine sections are new to this edition.

Access and Reform

Millions of American children and pregnant women lack health insurance and access to appropriate health care services. At least 30 states passed legislation in 1996 to improve various aspects of their health care systems or ordered studies to help them with future decisions. State insurance or managed care initiatives are contained in the insurance section.

- *Alabama* created an interim committee to study the potential effect of federal block grant funding and other proposed changes to Medicaid funding.

- *Arizona, Massachusetts, New York, Rhode Island* and *Utah* expanded Medicaid to certain populations.

- Several states and one territory—including *Arizona, Guam, Idaho, Maine, Maryland, Michigan, Mississippi, New Mexico, New Jersey, New York* and *South Carolina*—addressed indigent care. *Massachusetts* directed the Department of Public Health, after pubic hearings, to create health care facilities for the homeless. The Free Clinic Assistance Program in *the District of Columbia* is extended until 2001. *Kansas* enacted legislation allowing licensed dentists to provide dental care to the dentally indigent in specified not-for-profit health care facilities.

- *California* extended several programs funded by Cigarette and Tobacco Products Surtax Fund money, including the Comprehensive Perinatal Outreach, selected primary care clinics, Access for Infants and Mothers and emergency treatment for out-of-county indigent patients programs.

- *Connecticut* required a demonstration project be submitted to Health Care Financing Administration improve access to health care in areas where the viability of an acute care hospital is in question. It is to be developed by the departments of public health and social services and the Office of Health Care Access.

- *California* authorized the development of a registration program to permit certain health care providers from out of state to practice medicine across state lines. *Pennsylvania* and *North Carolina* addressed using volunteer providers to increase access to health care. *Virginia* clarified immunity from liability to health care providers if they provide services without charge. *North Carolina* required the occupational licensing board to track health care providers and to determine medical shortage areas.

- *Arizona* set aside $17 million each year from lottery revenues to fund six health and nutrition programs, including Health Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases. Arizona also made more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, by expanding eligibility to people who earn up to 100 percent of the federal poverty level.

- Several states—including *Idaho, Louisiana, Mississippi* and *Oklahoma*—that have passed medical savings account (MSA) legislation acted this year to amend their laws.

- *Florida* established the Children's Medical Services alternative service network to serve children with special health care needs who participate in the Children's Medical Services program.

- *Massachusetts* created a new public health commission to coordinate care responsive to the multicultural and multilingual needs of its service areas. The *Maine* Center for Public Health Practice was established to promote and coordinate health services research, training and policy efforts.

- Telemedicine was addressed in *Arizona, California, Connecticut, Georgia, Hawaii, Indiana, New Mexico* and *West Virginia*. See also the telemedicine section for more information.

- *Arizona* established the premium sharing project fund and the basic children's medical services program (subject to the availability of funds from the medically needy account of the tobacco tax and health care fund). *Florida* allowed the Healthy Kids Program to operate beyond a pilot basis and to operate sites additional without legislative approval.

- *Florida* strengthened the ability of the Agency for Health Care Administration (AHCA) to regulate the ways that Medicaid HMOs market and enroll members. In addition, Florida authorized a study of nonrisk-bearing alternative service networks for Medicaid recipients. *Maryland* required an assessment of the availability and accessibility of primary care services for Medicaid recipients.

- Several states—including *Arizona, Florida, New Jersey and New York*—worked to increase access for uninsured children. *Illinois* allowed discount insurance premiums through the Comprehensive Health Insurance Plan for elderly retired or unemployed participants if funds allow.

- Several states—including *Florida, New York, Kentucky, Maine, Pennsylvania* and *Vermont*—studied ways to or worked to improve quality of health services and consumer protection. *Maryland* ordered a study of reimbursement levels between managed care and other providers to monitor access to quality health care.

- COBRA benefits were was extended in *Florida* to employers with fewer than 20 employees. *Utah* provided a tax deduction for health care insurance if it was not deducted under the federal Internal Revenue Code. *South Dakota* addressed employer insurance coverage.

- Several states—including *Kentucky, Maine* and *Utah*—addressed health purchasing alliances to increase access to health care. Reimbursement rates for out-of-network providers will be the same as those for in-network providers in *Utah* if the insurer's providers or facility is not within 30 miles. Utah also has ordered a study of issues related to managed health care in rural and frontier areas of the state.

Adolescent Health

Although previous editions of this publication have contained a section on adolescent health, those issues are now covered in NCSL's publication, *Adolescent Health Issues: State Actions*.

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Child Fatalities

At least two states—*Kentucky* and *West Virginia*—adopted legislation in 1996 related to reviewing and preventing child deaths. *North Carolina* continued the Child Fatality Task Force and required that a report be submitted to the General Assembly.

Coordination

To increase efficiency and reduce duplication of services, many states consolidate programs or require them to work more closely together. *Arizona, Florida* and *Kentucky* required studies to be conducted to improve the efficiency of health service delivery.

- Several states passed laws to coordinate specific health and human services, including, *Delaware* (cancer awareness education), *Florida* (mental health and emergency care), *Hawaii* (mental health), *Iowa* (services for people with disabilities), *Idaho* (advanced life support and emergency medical services), *Michigan* (health and behavioral sciences) and *Mississippi* (children's mental health).
- *Tennessee* established that the new early education programs designed to address the health, education and social service needs of children must be developed through collaborative efforts.
- *Iowa* created a single entry point process for mental health, mental retardation and developmental disabilities. Iowa also enabled county agencies to establish multidisciplinary teams for more effective service delivery.
- *Connecticut* required that a demonstration project be developed to improve access to health care in areas where acute care hospital viability is in question. It is to be developed by the departments of public health and social services and the Office of Health Care Access.
- *Michigan, Nebraska, North Carolina* and *Vermont* merged several human service agencies. *Illinois* consolidated several agencies to create the Department of Human Services and directed a task force to make recommendations on further consolidation.
- *Hawaii* made appropriations to the departments of education, human services and health, requiring them to work together to provide services through school-based health centers. *Delaware* and *Utah* encouraged collaboration between school districts, local health departments and private medical providers to determine the needs of and the risks to students' health.
- *Florida* authorized a study of nonrisk-bearing alternative service networks for Medicaid recipients. Within existing resources, the Agency for Health Care Administration is directed to work with the Department of Insurance, the Department of Health and Rehabilitative Services, the Department of Education, the Department of Elderly Affairs and provider groups.
- *Idaho* required the Department of Health and Welfare to establish a statewide poison control center and to develop a system to consult with other state agency programs concerned with poisoning to develop consistent responses from the center. *Louisiana* requested the Commission on Perinatal Care and Prevention of Infant Mortality to invite the secretary of the Department of Social Services and the superintendent of the state Department for Education to its meetings.

Data and Quality

States recognize the importance of gathering consistent, easily accessible data to measure health outcomes and use patterns. Good data can help policymakers identify problems, discover whether programs are working and better direct resources where needed.

- *Connecticut* eliminated the requirement that 2 percent of the Maternal and Child Health Protection Program's funds be reserved for program evaluation. The act also requires the Department of Public Health to evaluate the program using outcome measures.

- *Florida* requires a health care quality improvement system for all Medicaid contractors and a toll-free telephone number to handle consumer complaints and maintain a statewide database of the complaints.

- Several states—including *Hawaii, Illinois, Iowa, Maine* and *Utah*—passed laws addressing or amending the state's health data collection.

- *Maine, Massachusetts* and *Vermont* addressed quality control and quality improvement in laws this year. The *Massachusetts* law also allows the creation of individual provider profiles that are disseminated to the public.

- *Minnesota* specifies that provider organizations and individual health care providers are to use the first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration as their unique provider number. The Minnesota act also establishes procedures for disclosing certain nonpublic data to related group purchasers and authorizes the release to the public of information collected from birth registrations.

- *New York* enacted the Pesticide Registry Act and established a computerized pesticide database.

- A *Tennessee* law requires the TennCare Bureau to file a report containing data and statistics relative to health care provided to women. It also requires data measures to assess the effectiveness of presumptive eligibility, the distribution of providers and the incidences of early prenatal care.

- *Maine* and *Utah* addressed confidentiality for health data.

- *Vermont* combined the administration of health care and the quality and cost control oversight into one department

Emergency Medical Services (with an emphasis on access and children's issues)

Children have unique needs when it comes to emergency medical services. Lifesaving equipment that works for an adult may be inappropriate for a small child, and children sometimes exhibit different symptoms than adults in a life-threatening situation.

- *Arizona, Georgia, Maryland, Pennsylvania* and *West Virginia* enacted laws requiring health plans to provide coverage for emergency services without prior plan authorization.

- *California* created the Emergency Medical Services for Children Program and limited program expenditures to $120,000 per fiscal year.

- *Delaware* created a statewide trauma care system and provided for the creation of a statewide trauma plan.

- *Idaho* charged the Department of Health and Welfare to establish a statewide poison control center that provides 24-hour emergency telephone service.

- *Iowa, New Jersey* and *Ohio* addressed regulatory issues for emergency personnel. Iowa directed its Law Enforcement Academy to establish minimum standards for the training of telecommunicators. New Jersey allowed police and fire personnel to provide cardiac defibrillation services and Ohio established the scope of practice of a "first responder" and required its state Board of Emergency Medical Services to certify as such an applicant who is a volunteer for a nonprofit emergency medical service organization or nonprofit fire department.

- *Illinois* authorized a Freestanding Emergency Center Demonstration License to certain facilities. In addition, people convicted of firearm or drug crimes must pay a $100 fee to go to the Trauma Center Fund for distribution to hospitals designated as trauma centers.

- *New Mexico* addressed expanded emergency medical services (EMS) by requesting its Human Services Department to include expanded EMS for reimbursement under Medicaid and requesting its Department of Health to study the feasibility of expanded EMS in rural, medically underserved communities in the state as one major asset to be included in any managed care plans for the area.

- *California* and *Illinois* enacted laws dealing with hospitals and EMS. California allowed a county hospital to close and contract with noncounty hospitals for emergency room services without risk of losing state funding for indigent care. Illinois allowed its Department of Public Health to investigate a hospital in an EMS system that goes on "bypass status" and required related reporting and contingency planning.

Health Promotion

State legislatures play an important role in ensuring the health of the citizens in their states. State activities range from promoting and funding certain practices—such as childhood immunizations—to increasing public awareness about hazards and prevention activities.

- *Pennsylvania* established the position of Office of Physician General within the Department of Health to advise the governor and the secretary of health on health policy, including the promotion of wellness and public health.

- *Florida* established the osteoporosis prevention and education program and required health plans to cover osteoporosis screening, diagnosis, treatment and management. *Delaware* requested that its Division of Public Health provide leadership in the promotion of public awareness and knowledge of osteoporosis. *West Virginia* created the Osteoporosis Prevention Education Act.

- *Florida* brought attention to important health issues by recognizing a week in March as Poison Prevention Week, a week in April as Infant Immunization Week, the month of April as Early Intervention Awareness Month and October as Breast Cancer Awareness Month. *Hawaii* affirmed the vital role of the Pacific Health Promotion and Development Center and encouraged the governor to continue to support its activities.

- *Delaware* established a Breast Cancer Education and Early Detection Fund supported through an income tax return designation. *Michigan* appropriated money to the Department of Community Health to promote awareness, education and early detection of breast, cervical and prostate cancer and to provide for other health promotion and medical activities.

- *Florida* prohibited smoking on, in or near school property and authorized law enforcement officers to issue citations for violations. An *Oregon* ballot initiative increased the state's cigarette tax with the majority of the tax going to the Oregon Health Plan for tobacco use reduction programs. The measure also adds one-time taxes per cigarette and retains a one-half cent per cigarette tax that funds the Oregon Health Plan.

- *Maryland* enacted a law requiring each hospital to offer mammography educational materials to each female patient when medically appropriate for the patient.

Environmental Hazards

State activities to ensure safe environments for children have increased during the past few years, most notably in the area of lead exposure. This publication does not include laws related to safe drinking water, waste disposal or similar environmental issues, which are covered by NCSL's Energy, Science and Natural Resources Program.

- *New York* created a Health Research Science Board within the Department of Health and a Pesticide Registry Act to assess the effect of pesticides on human health.

- Several states—including *Iowa, Kentucky, Maine* and *Vermont*—and the District of Columbia amended their existing lead poisoning prevention programs or created new ones.

Financing

Funding health care services and continuing efforts to contain health care costs remain challenges for states.

- *Alabama* appropriated funds to the sickle cell education program.

- *Arizona* expanded the use of funds in the medical services stabilization fund to be used to offset increases in the cost of providing levels of services to people eligible for Arizona's Health care Cost Containment System (AHCCCS). It also established the premium sharing demonstration project fund and the basic children's medical services program subject to availability of funds. The act addresses funding for medical services for needy children who are not eligible for AHCCCS.

- Proposition 203 in *Arizona* expanded eligibility for AHCCCS to 100 percent of the federal poverty level and set aside lottery revenues to fund six health and nutrition programs.

- Breast cancer research and education were addressed in laws and resolutions in *California, Delaware* and *New York*.

- *California* enacted laws regarding disproportionate share and extended programs funded by the money from the cigarette and tobacco surtax.

- *Hawaii* established a newborn metabolic screening special fund.

- Laws relating to care and financing care for the medically indigent passed in *Idaho, Mississippi, New Jersey, New Mexico, New York* and *Rhode Island*. New York's law also dealt with rate-setting and financing for graduate medical education, the Child Health Plus program and a grant program to improve health status and quality of care. The act established the New York State Small Business Health Insurance Partnership Program and addressed rural health issues.

- *Illinois* created a Medical Research and Development Fund and a Post-Tertiary Clinical Services Fund. It also created a Trauma Center Fund with a fee imposed on people convicted of firearm or drug crimes.

- Local governments in *Illinois* that offer general assistance were given the authority to choose to pay for medical care for emergency care only.

- *Iowa* enacted a law relating to public assistance and individual state tax-exempt accounts for certain emergency medical costs.

- *Kentucky* phased out the provider tax on physicians.

- People who maintain a household that includes one or more dependents who are physically or mentally incapable of caring for themselves now can take a credit against the state income tax in *Louisiana*.

- *Maine* created the Maine Health Data Organization with temporary financing from an assessment on hospital gross patient revenues. The act also addressed charity care guidelines for hospitals, quality improvement research and comprehensive health planning.

- *Maine* also passed a law requiring that money saved due to the closure of state mental health facilities or a reduction in services by the Department of Mental Health, Mental Retardation and

Substance Abuse Services be used to provide those services in other appropriate settings and programs.

- The Health Resources Planning Commission Fund was established by a law in *Maryland.*
- *Massachusetts* expanded Medicaid eligibility for children under 200 percent of poverty and increased the cigarette tax. *Oregon* also increased the state's cigarette tax through a ballot initiative with the majority of the tax going to the Oregon Health Plan.
- *Utah* provided a tax deduction for health care insurance.
- *Rhode Island* authorized a limit to reimbursement for services in the state's Medicaid program and increased the transition payment to community health centers. The act addressed uncompensated care and the reimbursement hospitals are eligible to receive for treating patients that have no coverage.
- *Rhode Island* resolved that the attorney general initiate action against tobacco companies to reimburse Medicaid for expenses related to smoking-related disease.
- *South Carolina* granted the Medical University of South Carolina the authority to enter into reasonable agreement to transfer the management and operation of the Medical University Hospital to private operators.
- *Utah* required that family support services and associated care management services for people with disabilities to be provided through vouchers or direct financial assistance.
- *Vermont* clarified that Medicaid is the payer of last resort.

Immunization

Many states have continued the recent trend toward improving immunization rates throughout the country, especially for low-income children.

- *New York* passed legislation requiring its public assistance program to provide information and a schedule for age-appropriate immunizations. *Iowa* directed the Department of Human Services to determine immunization status of children on public assistance and make referrals to local public health departments for immunizations.
- *California* and *Missouri* required managed care organizations and health insurance companies to provide routine childhood vaccine coverage. *Minnesota* extended its mandated coverage for immunizations to children from birth to age 18.
- *Arizona, Georgia, Michigan* and *Virginia* established immunization registries to help track whether children receive the recommended shots. *Wisconsin* required that an annual report on immunization status be submitted to the legislature annually.
- *Kentucky, Missouri* and *Pennsylvania* adopted new requirements concerning hepatitis B vaccines. *Kentucky* also requires immunizations against measles, mumps and Haemophilis influenza type B in addition to those currently required under state law. *Minnesota* passed legislation for a study to submit recommendations for state immunization policy about vaccine-preventable diseases that currently are not required under state law.
- *Michigan* and *South Dakota* adopted legislation to allow health care providers and schools to share immunization information with service providers that are caring for patients. *Kansas* granted certain people the authority to disclose immunization status without parental consent. Colorado passed legislation allowing parents or caretakers the authority to delegate their authority to certain people to immunize a minor child.

- *Kentucky* required schools and day care centers to have immunization certificates within two weeks of a child's attendance. *Illinois* established a 60-day period for school children to show proof of immunization.
- As part of its immunization education efforts, *New York* established a toll-free number to provide information about the importance of immunizations and the newborn schedule.
- *Florida* established an Infant Immunization Week.
- *Massachusetts* transferred the state laboratory institute, which has responsibility for developing and producing childhood vaccines, from the Department of Public Health to the University of Massachusetts.

Injury Prevention

States approached injury prevention efforts from many angles, including child passenger restraints, poison control and boating safety requirements. Bicycle helmet requirements also save lives and health care money.

- *Maryland* and *Rhode Island* established or amended their child passenger restraint laws. Safety legislation passed in *Wisconsin* prohibits children from riding in the open cargo area of trucks.
- Bicycle safety legislation passed in *Florida* and *West Virginia*. *Utah* established that a person operating an electric-assisted bicycle must have a driver's license.
- *New York* passed in-line skate safety legislation.
- *Idaho* passed poison control legislation. *Florida* established a Poison Prevention Week.
- *Alabama* designated an Emergency Medical Services Week.
- Boating safety legislation passed in several states, including *Florida, Indiana, Mississippi, New Jersey* and *New York*. *Minnesota, New York* and *Oklahoma* and *South Carolina* created safety standards for personal watercraft or JetSki-style machines.
- *Connecticut* and *Michigan* passed legislation concerning school crossings. *Massachusetts* established "safety zones" with 20-mile-per-hour speed limits.
- *Florida* and *New York* adopted certain health and safety standards for school bus drivers. *Hawaii* and *Massachusetts* passed school bus safety legislation. *New York* also passed legislation to improve school bus safety, including imposing fines for passing a stopped school bus.
- *Washington* passed legislation prohibiting the use of used cribs that do not meet federal safety requirements.
- *Tennessee* passed legislation requiring the Department of Health and Human Services to develop informational materials about shaken baby syndrome for distribution to various health care facilities and welfare agencies.
- Shopping cart safety requirements were established in *New York*.

Insurance

More than 44 states passed legislation related to insurance or managed care in 1996, resulting in more than 230 acts. This was a very active year for managed care regulation. Actions ranged from providing enrollees in managed care with direct access to certain health care providers--most frequently obstetricians and gynecologists--to preventing managed care organizations from limiting a physician's communication with a patient regarding treatment options. States also created the framework for medical savings accounts as an alternative to traditional insurance and continued to mandate health insurance coverage for specific illnesses and treatments.

This section is divided into the following subsections: access to providers in managed care, gag clauses, general, health insurance purchasing, individual and small group reform, mandated coverage, maternity issues, medical savings accounts, other consumer protections, preexisting conditions and continuation of coverage, protection for domestic violence victims and state-sponsored insurance.

- Several states enacted laws to require health insurance plans to cover services and treatments for certain conditions including *Alaska, Maine* and *Virginia* (cervical cancer screening), *Kentucky* (bone marrow transplants for treatment of breast cancer), *Maryland* and *Rhode Island* (breast reconstruction after mastectomy), *Oklahoma* and *Florida* (osteoporosis screening), *Alaska* and *Minnesota* (prostate cancer screening), *California* and *Minnesota* (immunizations for children), *Pennsylvania* and *Tennessee* (phenylketonuria) and *New Hampshire* (nonprescription enteral formulas). *Florida, Maine, Oklahoma* and *West Virginia* passed laws requiring health plans to provide coverage for diabetes supplies, including education services. *Maine* and *Virginia* require all health plans and insurers to cover pap tests. *Connecticut* prohibits health plans from refusing to cover an applicant who once suffered from breast cancer under certain conditions and exempts follow-up breast cancer examinations from preexisting condition exclusions. *Utah* provides that, if an insured person has coverage for maternity benefits, the policy must cover any prenatal or maternity expenses of a birth mother or child, if the child is adopted by the insured within 30 days of the child's birth.

- Access to providers in managed care was addressed by a number of states, including *Alabama, Colorado, Connecticut, Georgia, Illinois, Indiana, Maine* and *Virginia* (obstetricians and gynecologists), *California* (pharmacists) and *Kentucky* (chiropractors). Georgia requires the offering of a point-of-service option and *Washington* requires the disclosure of a point-of-service option. California law permits licensed nonphysician providers to bill the health plan directly for services and be listed in plan directories. *Utah* permits an insured person to choose a health care provider or facility when the insurer's provider or facility is not within 30 miles.

- Several states—including *California, Colorado, Delaware, Georgia, Indiana, Maine, Maryland, Massachusetts, New Hampshire, New York, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia* and *Washington*—passed legislation concerning gag clauses. *North Carolina* and *Texas* adopted regulations to address this issue.

- *Alaska, Connecticut, Florida, Georgia, Illinois, Iowa, Kansas, Kentucky, Maine, Missouri, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Virginia* and *Washington* prohibit insurers from limiting coverage for postpartum hospital stays for mothers and infants, with several of these states mandating postpartum home health care visits. *New Hampshire* passed a similar law and also mandated that insurers pay for medically necessary prenatal homemaker services. *Delaware* requested that all health care providers, insurers and HMOs to voluntarily adopt criteria regarding postpartum care of mothers and infants. *Utah* limits an insurer's ability to deny coverage for failure to obtain preauthorization for maternity care.

- *Delaware, Indiana, Minnesota, New Hampshire, New York, Pennsylvania* and *Tennessee* prohibit health care insurers and managed care organizations from denying, restricting, limiting or terminating a woman's plan because the woman is a victim of domestic violence.

- At least nine states—including *California, Georgia, Kansas, Maine, Maryland, Michigan, New York, South Dakota and Washington*—adopted legislation regulating grievance procedures in managed care. *California* requires HMOs and health insurers to establish an external, independent review process to examine grievances and appeals for denial of experimental treatment for individual enrollees who have terminal conditions.

- *Alabama, California, Georgia, Hawaii, Maine, Michigan* and *Utah* enacted laws regarding disclosure of information by health plans to enrollees.

- *California* and *Georgia* passed laws prohibiting health care service plan contracts from containing incentive plans that act as an inducement to deny, reduce, limit or delay medically necessary and appropriate services.

- *New Jersey, New York* and *Oklahoma* addressed the use of genetic testing information in health insurance coverage. *Florida* required insurers to maintain confidentiality of psychotherapeutic claims. *Washington, D.C.*, enacted a law to provide for the confidentiality of insurance information.

- *Arizona, Connecticut, Georgia, Kansas, Maryland, New Mexico, Pennsylvania, Washington* and *West Virginia* passed laws regarding health insurance and health plan coverage of emergency medical treatment.

- *Florida* created a volunteer statewide Managed Care Ombudsman Committee to act as a consumer protection and advocacy organization on behalf of all health plan enrollees.

- A *Maryland* law prohibits a health network from denying health care services to any enrollee based on gender, race, age, religion, national origin or other protected category under the Americans with Disabilities Act.

- *California* requires health plans to have and describe their policy for determining if a second medical opinion is medically necessary and appropriate.

- Several states adopted laws concerning coverage for people with preexisting conditions and continuation of insurance coverage for those who leave jobs or lose their insurance. The states include *California, Florida, Idaho, Indiana, Kansas, Kentucky, Maine, Michigan, South Carolina, South Dakota* and *Virginia*. The Florida and Michigan laws also require guaranteed renewal of health insurance policies.

- *Alaska, California, Colorado, Connecticut, Delaware, Indiana, Maryland, Michigan, New York, North Carolina, South Dakota, Tennessee* and *Virginia* enacted laws reforming the individual and small group insurance market.

- *California, Idaho, Indiana, Mississippi, Ohio, Oklahoma, Pennsylvania, Utah, West Virginia* and *Wisconsin* addressed medical savings accounts in legislation. *Idaho, Mississippi* and *Oklahoma* laws specifically enable state employees to participate in medical savings accounts.

- Thirteen states and *Guam* passed laws concerning state-sponsored insurance programs. *California, Kansas, Oklahoma* and *South Dakota* addressed high-risk pools. *Arizona, Connecticut, Florida, Massachusetts, New Hampshire* and *New Jersey* passed laws concerning health insurance coverage for children. The *Kansas* law relates to the right to coordinate benefits with a private carrier when medical assistance is furnished. *Minnesota* required integrated service networks to participate in the medical assistance, general assistance and Minnesota Care programs. Guam increased the benefit cap of the Catastrophic Illness Assistance Program.

- *California, Colorado, Illinois, Maine* and *Utah* enacted laws establishing or further defining health insurance purchasing alliances or cooperatives.

- *Idaho* and *Indiana* authorized studies of managed care. *Louisiana* created a commission to study parity in mental health benefits.

- *Washington, D.C.*, requires the use of a uniform health insurance claim form.

- *Colorado* and *Idaho* passed laws regarding health insurance coverage for children pursuant to a court order. *Kentucky* added medical support, maintenance and medical support insurance to the factors to be considered in determining wage withholdings for child support.

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- Risk-based capital was the focus of laws enacted in *Idaho* and *Indiana*, while *West Virginia* created the Health Maintenance Organization Guaranty Association, a mandatory membership association for all HMOs.
- *Iowa* required third-party payers to pay for services of physician assistants or advanced registered nurse practitioners.
- Charitable health care providers must be offered the same professional liability insurance coverage as noncharitable providers in *Kentucky*.
- *Kentucky* made numerous changes to the comprehensive health reform legislation enacted in 1994.
- *Louisiana* enacted legislation regarding certificate of authority for HMOs.
- A *Maryland* act repealed existing loss and ratio guidelines and established new guidelines. It also created a loss and ratio benchmark for the individual market.
- Exclusivity contracts are prohibited between health care insurers and health care providers in *New Hampshire*.
- *Mississippi* amended current law to authorize the regional mental health and mental retardation commissions to enter into managed care contracts.
- *New York* enacted a comprehensive law dealing with rate-setting and financing for graduate medical education, insurance programs for the uninsured, the Child Health Plus program and grant programs to improve health status and quality of care. The act establishes the New York State Small Business Health Insurance Partnership Program and addresses rural health issues.
- *North Carolina* gave public hospitals the authority to acquire ownership in a managed care company and made confidential any financial information related to a third-party payer contract or arrangement.
- *Oklahoma* enacted a law to address insurer and health plan discount rates.
- *Pennsylvania* passed the Health Filing Reform Act, which requires each hospital plan, health services plan and HMO to establish a base rate that is not excessive, inadequate or unfairly discriminatory.
- Utilization review organizations must be registered, according to a law passed in *South Dakota*.
- *Utah* provided a tax deduction for health care insurance.
- The Council on Health Care Fraud and Abuse was created in *Wisconsin*.

Legal and Ethical

Because advances in technology and finite resources, health care providers and policymakers confront difficult decisions about services and treatment. Questions about an individual's rights concerning access to needed treatment, the right to refuse medical care and rights related to medical information also continue to be debated in legislatures.

- *South Carolina* allowed family courts to order medical treatment for a child who is in danger of permanent harm or death because the parents refused to consent based on religious grounds.
- Breast-feeding mothers are exempted in *Wisconsin* from a law that makes exposure of sexual organs to a child a misdemeanor.

- *Iowa* modified a provision in the law that prohibits the use of a positive drug or alcohol test in the criminal prosecution of a mother who exposed her child to a substance perinatally. *Wisconsin* removed foster care workers from the list of people who are allowed to refer an infant to a doctor for testing for drugs due to the mother's use of drugs during pregnancy.

- *Ohio* prohibited the sale of expired drugs, baby food and infant formula. Ohio also allowed an individual to posses hypodermic needles and insulin if licensed to provide diabetes education.

- Several states—including *California, Rhode Island* and *Wisconsin*—enacted legislation banning female genital mutilation. *Louisiana* urged Congress and the president to use their influence in international relations to end the practice.

- *New York* and *New Jersey* addressed the use of genetic testing information in health insurance coverage. *Oklahoma* created the Task Force on Prevention of Genetic Discrimination to study issues in genetic discrimination in insurance and employment.

- Penalties for battery to pregnant victims were increased in *Idaho*.

- *New York* directed the commissioner of health to establish a program to test newborns for HIV. Regulations must address the administration of testing, counseling, tracking and disclosure of test results. *Delaware* required health care providers to advise pregnant women of the value of HIV testing and request that each pregnant woman give informed consent to be tested. *Florida* required doctors and midwives to offer HIV testing to all pregnant women. *Hawaii* requested that the Department of Health form a working group to develop a plan to ensure that HIV education, counseling and testing is offered to women of childbearing age.

- *Illinois* enacted a law related to medical liability and general assistance. *Virginia* clarified immunity from liability for health care providers who deliver services without charge.

- *Michigan* clarified that the school code does not mandate physical examinations or medical treatment of students. *Utah* required local school boards to implement rules by the Department of Health to give students spinal curvature exams. The rules must include an exemption for students whose parents object to the exam.

- *Hawaii* requested the Department of Health to develop standards and procedures, in consultation with several organizations, to govern decisions to sterilize incapacitated minors.

- *Tennessee* required health care providers who know or suspect that a patient's injuries are due to domestic violence to make a report to a local law enforcement agency.

- Several states—including *Florida, Hawaii, Rhode Island* and the *District of Columbia*—addressed medical record confidentiality. *New York* established an adoption medical information registry for birth parents to provide medical information. *Michigan* and *Wisconsin* addressed child custody and medical information.

Medicaid

Medicaid remains the primary source of health insurance for people who live in poverty. The program also remains a major budget concern for states, which continue their search for ways to cut costs. Several states prepared for anticipated federal changes to Medicaid under proposed federal block grants and welfare reform. The expected major Medicaid reforms did not pass Congress.

- Anticipating Medicaid changes, *Alabama* created an interim committee to study the potential effect of federal block grant funding and other proposed changes to Medicaid funding. *North Carolina* continued the Medicaid Task Force. *Hawaii* appropriated $96 million in federal funds to the Department of Human Services for the medical assistance program, Hawaii QUEST and the Medicaid program in anticipation of a new federal block grant. *New Mexico* directed the social services department to include consumers and providers in decision-making about block grant distribution.

- Several states —including *Florida, Indiana, Maine, Ohio* and *South Carolina*—prepared for or made changes to Medicaid in preparation for welfare reform. *Wyoming* enacted welfare reform provisions that limit medical assistance programs to five years but specified that children in noncompliant households would continue to be covered. *Pennsylvania* required recipients of medical assistance to pay a $150 deductible each fiscal year for certain medical services. *Michigan* authorized a pilot project for people who work their way off welfare to purchase Medicaid coverage.

- *Florida* strengthened the ability of the Agency for Health Care Administration to regulate the ways that Medicaid HMOs enroll and market to new members. In addition, Florida authorized a study of nonrisk-bearing alternative service networks for Medicaid recipients. *Maryland* required an assessment of the availability and accessibility of primary care services for Medicaid recipients.

- *Arizona, Massachusetts, New York, Rhode Island* and *Utah* expanded Medicaid to certain populations. Massachusetts used a 25-cent per pack cigarette tax to fund expansion of the Medicaid program and the Children's Medical Security Plan.

- *Alaska* and *Maryland* (moved to require) managed care for their Medicaid populations. *Mississippi* ordered a study and recommendations on moving the state to Medicaid managed care. *Oklahoma* postponed the expansion of Medicaid managed care to include all AFDC and medically needy participants. *Michigan* increased Medicaid managed care enrollment to include the elderly, the disabled, the medically needy, those with mental illness, those who have developmental disabilities, children with serious emotional disturbance and recipients of children's special health care services.

- *Minnesota* required managed care organizations to file action plans describing the plan's public health goals for service areas. As a condition of licensure, Integrated service networks are required to participate in the medical assistance, general assistance and MinnesotaCare programs.

- *New York* extended the state Medicaid managed care program for four additional years and clarified which Medicaid recipients must participate. Pregnant women may choose not to participate in mandatory managed care if they are in an established relationship with a comprehensive prenatal care provider that is not in a managed care program. Health services may be provided on a capitated basis to people with HIV infection and to people with mental illness. *Utah* amended the state's Medicaid freedom of choice waiver to allow contracts with private insurers, including HMOs and other private health care delivery organizations.

- Family practice programs in *Indiana* may encode Medicaid identification cards with the name of the residency program, rather than the name of the individual provider in residency at a Medicaid managed care program. Provider organizations and individual providers in *Minnesota* are required to use as their provider number the first eight digits of the national provider identifier maintained by the Health Care Financing Administration (HCFA).

- *Virginia* allowed other entities, in addition to local social services departments, to determine eligibility for medical assistance if they are approved by the Board of Medical Assistance Services.

- *Michigan* required the Department of Community Health to ensure that children in Medicaid managed care have timely access to early periodic screening, diagnosis and treatment (EPSDT) services. The state may contract only with HMOs that provide patient-based data, including immunizations, EPSDT, substance abuse services, and maternal and infant support service referrals. Michigan may contract only with HMOs that ensure prenatal care and cover minimum length of postpartum stays for mothers and their newborns. *Ohio* and *Kansas* addressed postpartum inpatient coverage for mothers and newborns. In Kansas, no health plan policy may exclude or restrict coverage for maternity benefits to an individual because Medicaid benefits are available for the same condition.

- *New York* restored full Medicaid fee-for-service reimbursement for physician services delivered in a hospital emergency room or outpatient department retroactive to July 1, 1995. New York extended the Medicaid Physician Case Management and Prepaid Health Service Programs for an additional year.

- The Department of Health Services in *California* is authorized to enroll Medi-Cal eligible people in a county-operated fee-for-service managed care pilot program. County board supervisors are to advise counties about the implementation and operation of the program. The commissioner of human services in *Minnesota* is directed to seek a federal waiver to allow a fee-for-service option to MinnesotaCare enrollees.

- *New Mexico* called for a "broad based public process" to develop consensus on how to allocate Medicaid resources. The public review process must include a series of public hearings and seek testimony from advocates for senior citizens, people with disabilities, mental health consumers, low-income individuals, Medicaid recipients and providers or potential providers for the Medicaid program.

- *Arizona* established a three-year market competition pilot program for inpatient hospital reimbursement rates for urban health plans and program contractors. Health plans are required to contract and negotiate reimbursement rates with one or more hospitals in the pilot counties. Arizona also began the premium sharing demonstration project fund and the basic children's medical services program, subject to the availability of funds from the tobacco tax and health care fund.

- *Pennsylvania* required managed care entities under contract to the Department of Public Welfare to contract on an equal basis with any pharmacy that is qualified to participate in the Medical Assistance Program that is willing to comply with rates, terms and quality standards established by the managed care entity.

- *Arizona* required the Arizona Health Care Cost Containment System to apply for a federal waiver to reimburse licensed midwives. *North Carolina* authorized Medicaid to cover physical and speech therapy. *Virginia* provided for the direct payment of licensed clinical social workers and counselors reimbursable by Medicaid. *Kentucky* allowed the Medical Assistance Program to pay for chiropractic services. *Idaho* allowed reimbursement for intermediate care facilities for people with mental retardation to be based on a prospective rate system. *New Mexico* requested the Department of Human Services to reimburse emergency medical services through Medicaid. *Wisconsin* submitted an amendment to the state medical assistance plan to receive federal financial participation for removable prosthodontic services (e.g., dentures and bridges).

- *New Mexico* allowed entities that contract with the state to provide Medicaid managed care to negotiate reimbursement rates with providers and to report provider rate fee increases. *Rhode Island* limited reimbursements for Medicaid to in-state and out-of-state hospitals for inpatient services (up to $75,000 per admission) and addressed uncompensated care. *Maryland* ordered examination of the use and reimbursement levels between managed care organizations and other providers of health services. *New Hampshire* and *Mississippi* also addressed Medicaid reimbursement rates.

- *Indiana* formed a joint committee to investigate Medicaid reimbursement and provider claims. *Nevada* adopted the False Medicaid Claims Act, which allows the state to file civil action against anyone who makes a false claim and to collect damages and investigation costs. *North Carolina* provided incentives to counties to recover fraudulently spent Medicaid funds. *Wisconsin* created the Council on Health Care Fraud and Abuse.

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- The Department of Social and Rehabilitation Services in *Kansas* is authorized to coordinate benefits with private carriers when someone who has private insurance also receives medical assistance.

- *Wisconsin* required providers to collect copayments, coinsurance or deductibles unless the cost of collection exceeds the amount to be collected.

- *California* increased payments to disproportionate share hospitals under the newly established Medi-Cal Supplemental Payments program. The nonfederal share of these supplemental payments would come from the University of California hospitals through a special transfer provision. California reduced the state fee paid by public hospitals that participate in the disproportionate share hospital program. Hospitals that meet the existing disproportionate share hospital criteria and are designated by the National Cancer Institute as comprehensive or clinical research facilities may participate in the Emergency Services and Supplemental Payments Fund.

- *New Jersey* provided that each local school district that participates in the Special Education Medicaid Initiative receive a percentage of the federal revenue yields for that year. *Virginia* called for the departments of medical assistance and education to examine funding for the pilot school and community health centers and make revisions designed to provide cost-effective access to health care for poor children.

- *Maine* required pharmacies to pay a 25-cent per prescription processing service fee on every Medicaid prescription to be deposited into the Medical Care-Payments to Providers Special Revenue account. *Georgia* required the Department of Medical Assistance to exclude pharmacy services in the HMO pilot and allow acute care hospitals statewide to contract with Medicaid for services on a nonrisk capitated rate and to implement an automated prospective drug utilization review program. *Indiana* allowed Medicaid providers to forgo the required copayment if the Medicaid recipient does not make the copayment. *Hawaii* required a study of the various drug therapies used in the Med-QUEST Program.

- *California* extended family planning benefits to women who would otherwise lose benefits under Medi-Cal, the state's Medicaid program. California revised the eligibility requirements for Medi-Cal benefits for families that lose eligibility due to the reuniting of separated spouses. Proposition 99 funds may be used for the perinatal services and perinatal outreach coordination under the Medi-Cal program.

- Several states—including *California, Florida, Minnesota, Tennessee* (TennCare's pharmacy program) and *Virginia*—addressed consumer protection issues in Medicaid managed care.

- *Indiana* required the Office of Medicaid Policy and Planning to seek a federal waiver to increase the number of waiver slots for individuals that use an intermediate care facility for the mentally retarded under a home- and community-based waiver. *Louisiana* requested the secretary of the Department of Health and Hospitals not to cut funding for people with mental retardation and developmental disabilities and not to cut waiver slots for MR/DD-eligible individuals. *Utah* required that family support services be offered in the form of vouchers to be used by people with disabilities. Nearly $5 million in cuts in 1995 were restored by *Minnesota* to a program that helps people with disabilities live independently at home instead of in a group home or nursing home. A study was ordered to report on strategies for supporting families with medically fragile and technology dependent children.

- *Florida* established the Department of Health as the single agency responsible for all state health matters.

- *California* passed legislation to suspend (until January 1, 1999) the operative date for the establishment of a drug formulary and required the Bureau of State Audits to report on the drug program management techniques and the comparability of the program to other private sector third-party payers. The legislation also extended Medi-Cal's authority to contract for single-source and multi-source drugs and the 10 percent supplemental rebate program.

- *Oregon* increased the state's cigarette tax from 1.4 cents to 2.9 cents per cigarette, with the majority of the tax going to the Oregon Health Plan for tobacco use reduction programs. *Rhode Island* requested the state attorney general to file suit against tobacco companies to reimburse the state for expenses incurred by the Medicaid program due to smoking.
- *Vermont* and *Kentucky* clarified that Medicaid is the payer of last resort.
- *Kentucky* made numerous changes to the comprehensive health reform legislation enacted in 1994, including repealing the request for a federal waiver to require Medicaid recipients to pay copayments on certain services. Also repealed were the discount option program, to permit low-income people to buy health care services at Medicaid rates; and mandatory enrollment for noninstitutionalized aged, blind and disabled recipients in Medicaid managed care. Medicaid payments for services provided in Kentucky by an out-of-state health facility or services are prohibited if the facility or service does not have a certificate of need.
- Maine established an electronic benefit transfer system for the welfare, food stamp and Medicaid programs. *Minnesota* required that an enhanced automation system be created to educate public assistance recipients about their health care options.
- *Maryland* required that an assessment of the current availability and accessibility of primary care services that are necessary to serve the Medicaid population and the uninsured be developed. Several states—including *Arizona, Indiana, Kansas* and *Mississippi*—addressed Medicaid and indigent care.
- *Minnesota* enacted legislation outlining state payment of medical assistance to Indians and directed the commissioner of human services to collect, analyze and report information about collaborative resources and nutrition services that are available to, and economic contributions by, migrant farmworkers.

Minority Health

A disproportionate share of minority populations lack health insurance and are at higher risk for health problems. Some minorities also face language or cultural barriers to receiving appropriate health care services.

- *Alabama* created the Sickle Cell Oversight and Regulatory Commission and made an appropriation from the Education Trust Fund to the sickle cell education program. *Florida* required the Department of Health and Rehabilitative Services to establish a sickle cell program to the extent that resources are available.
- *Delaware* and *New York* passed laws concerning recruitment of minorities who are interested in pursuing a medical education.
- *Hawaii* affirmed the vital role of the Pacific Health Promotion and Development Center and encouraged the governor to continue to support its activities. Hawaii also passed a resolution requesting the Department of Health to reinstitute health data collection procedures to gain a more complete statistical picture of the health status of Hawaii's minorities.
- *Massachusetts* created a new public health commission in Cambridge, which is to include programs that are responsive to the multicultural and multilingual composition of the service area.
- *Minnesota* enacted legislation outlining state payment of medical assistance to Indians and directed the commissioner of human services to collect, analyze and report information about

collaborative resources and nutrition services that are available to, and economic contributions by, migrant farmworkers.

Newborn Screening

Medical advances enable health care providers to identify more conditions that can cause health problems and disabilities. Most states require a variety of screenings for newborns. If found early, many problems can be corrected or improved with treatment or support services.

- *Hawaii* established a newborn metabolic screening fund to pay for laboratory testing, follow-up testing, educational materials, continuing education, quality assurance and equipment.
- *Colorado* eliminated certain diseases from its newborn screening regimen and required a second screening for PKU, cystic fibrosis, hypothyroidism and other metabolic disorders.
- *New Hampshire* required that health insurers cover two postpartum visits, during which the infant would be screened for genetic and metabolic diseases in cases where the length of hospital stay is shorter than the current nationally accepted guidelines. *Ohio's* maternity benefits law addressed screening for phenylketonuria.
- *Minnesota* established that a birth defects registry be developed and maintained by the commissioner of health to monitor trends in birth defects, to investigate clusters of birth defects and to increase public awareness. *West Virginia* required physicians and midwives attending the birth of a child with a congenital deformity to report it to the Bureau of Public Health.
- Foster care workers are removed from the list of people who can refer an infant (due to a mother's use of controlled substances) to a physician to be tested for controlled substances in *Wisconsin.*
- *New York* directed the commissioner of health to establish a program to test newborns for HIV. Regulations must address the administration of testing, counseling, tracking and disclosure of test results.

Nutrition

Good nutrition is especially important for pregnant women and growing children. School nutrition programs, WIC and breast feeding issues received legislative support this session.

- *Arizona* set aside $17 million each year from lottery revenues to fund six health and nutrition programs, including Healthy Start and WIC.
- Breast-feeding mothers are exempted in *Wisconsin* from a law that makes exposure of sexual organs to a child a misdemeanor.
- *Utah* required each local school board to review why any school in its district does not participate in the school breakfast program. Utah also clarified that purchases made under WIC are exempted from sales and use tax.
- *Pennsylvania* added wildlife donations to the Donated Food Limited Liability Act to be used for charitable food programs.
- *Ohio* prohibited the sale of expired drugs, baby food and infant formula.

Oral Health

Oral health and dental care for children did not draw much attention in state capitols in 1996.

- *Pennsylvania* required the Department of Health to apportion the Commonwealth into dental health districts administered by a public health dentist who is to implement dental health policies and programs.

- *Kansas* established that a dentist who provides services for people without dental coverage is immune from liability.

Pharmaceuticals

States enacted laws to address issues of access to pharmaceuticals. Extending prescriptive authority to health care providers and legislation pertaining to pharmacies and pharmacists were the most common actions taken in 1996.

- *California, Kentucky, Oklahoma* and *Rhode Island* passed laws regarding prescriptive authority for nurse practitioners. *Kansas* expanded the scope of practice for nurse anesthetists to include, under order of a physician or dentist, developing a general plan of anesthesia care, selecting the method for administration, and inducing and maintaining required levels. *West Virginia* extended limited prescriptive authority to physician assistants (PA) and outlined educational requirements to be eligible for and maintain prescriptive privileges. *Florida* authorized supervisory physicians to grant PAs the authority to prescribe drugs with some limitations. *Tennessee* required the division of health-related boards to provide the board of pharmacy with the names of all nurse practitioners and physician assistants who are authorized to issue prescriptions and legend drugs and their supervising physician.

- *California, Guam* and *Hawaii* authorized optometrists to use certain topical therapeutic pharmaceutical agents and in Guam to use additional oral and topical agents under a comanagement arrangement with an ophthalmologist. *California's* expanded scope of practice also allowed optometrists to diagnose and treat specified conditions or diseases of the human eye or its appendages.

- *Pennsylvania* required managed care entities under contract to the Department of Public Welfare to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance Program that is willing to comply with rates, terms and quality standards established by the managed care entity.

- A *Delaware* resolution and an *Ohio* law addressed the use of off-label drugs and insurance reimbursements. *New Jersey* memorialized Congress to enact legislation to facilitate the rapid review and approval of innovative drugs and other items without compromising patient safety or product effectiveness.

- *Maine* passed legislation that requires health plans to provide information about procedures that enrollees must follow to obtain drugs and medicines that are subject to a plan list or formulary. *Washington* passed similar legislation that requires the health carrier to disclose whether a plan provider is restricted to prescribing drugs from a plan list, what drugs are on the list and the extent to which enrollees will be reimbursed for drugs not on the list.

- *Hawaii* required a study on the various drug therapies used in the Med-QUEST Program.

- *Hawaii* requested the Department of Health to form a working group to ensure that AZT treatment is offered to HIV positive women, if appropriate.

- *California* passed legislation to suspend (until January 1, 1999) the operative date for the establishment of a drug formulary and required the Bureau of State Audits to report on the drug program management techniques and the comparability of the program to other private sector third-party payers. The legislation also extended Medi-Cal's authority to contract for single-source and multi-source drugs and the 10 percent supplemental rebate program.

- *Florida* allowed chiropractors to authorize the ordering, storing and administering of prescription medical oxygen and certain topical anesthetics in aerosol form under emergency circumstances and revised other chiropractic rules relating to prescribing, dispensing and administering medicinal drugs and keeping written records.

- *Maine* passed legislation granting naturopathic doctors limited prescriptive authority. A 12-month collaborative relationship with a licensed allopathic or osteopathic physician to review the naturopathic doctor's prescribing practices is required before the naturopathic doctor can independently prescribe noncontrolled legend drugs.

- *California* and *Mississippi* enacted laws addressing the payment of pharmacist services. *Indiana* authorized licensed pharmacists to adjust a patient's drug regimen in a health care facility under certain circumstances. An *Ohio* law permits and outlines procedures for registered pharmacists to sell dialysis drugs and supplies directly to the patients for self-administration, according to a physician's orders. *Tennessee* authorized pharmacists to conduct and assist patients with tests approved for in-home use.

- *Utah* created the Pharmacy Practice Act. Among other things, the act prohibits the sale of prescription drugs unless the stock container bears a label containing the name, business and address of the manufacturer. Third-party payers for pharmaceutical services within the state may not require any pharmacy patient to obtain a drug from out of state as a condition for obtaining third-party payment and allows pharmacists or pharmacy interns who are dispensing a prescription order for a specific drug brand to substitute another drug product equivalent, with some limitations.

- *Maine* required pharmacies to pay a 25 cent per prescription processing service fee on every Medicaid prescription to be deposited into the Medical Care-Payments to Providers Special Revenue account. *Georgia* required the Department of Medical Assistance to exclude pharmacy services in the HMO pilot program and to implement an automated prospective drug use review program.

- *Massachusetts* established a program of pharmacy assistance for certain people with disabilities and the elderly who are not eligible for medical assistance or other third-party coverage for pharmacy benefits.

- *Maryland* allowed the medical assistance program to pay for a generic drug as soon as it is added to the state formulary.

- *Ohio* prohibited the sale of expired drugs, authorized individuals certified to conduct diabetes education to possess insulin if they meet certain requirements and authorized possession of hypodermic needles for educational purposes.

- *Minnesota* is developing a plan to provide prescription drugs at discounted prices to those 65 years of age or older whose income is below 200 percent of the current federal poverty line. *Louisiana* requested the Louisiana Health Care Authority and the Louisiana Primary Care Association to jointly develop a pilot program to provide prescription drugs for the authority's indigent outpatients. *Oklahoma* authorized the state to join a multi-state purchasing consortium for the purpose of purchasing pharmaceuticals and other medical supplies.

- *Pennsylvania* passed legislation requiring manufacturers of prescription drugs that are reimbursed under PACE, PACENET and designated pharmaceutical programs to enter into a rebate agreement with the Department of Aging to obtain reimbursement.

- *Tennessee* ordered a study of the TennCare pharmacy program, with a report due by January 1997.

Prenatal Care and Infant Mortality Reduction

The United States continues to lag behind its industrial counterparts in infant mortality and the rate of infants born at low birthweight. Many infant deaths and health problems stemming from babies being born too small can be prevented or reduced through prenatal care and newborn screenings. Laws related to maternity length of stay are listed in a subsection under insurance.

- *Ohio* required the state Medicaid program and health policies that cover maternity benefits to cover a mother and her newborn child for a minimum of 48 hours of inpatient maternity care after a normal vaginal delivery and 96 hours for a Cesarean delivery. *Michigan* required that the Department of Community Health may contract only with HMOs that ensure prenatal care and cover minimum length of postpartum stays for mothers and their newborns. *Kansas* required any health plan that provides maternity services to provide for nationally accepted minimum postpartum stays.

- Health insurance policies are encouraged in *Delaware* to cover prescription strength prenatal vitamins.

- *California* extended several programs funded by Cigarette and Tobacco Products Surtax Fund money, including the Comprehensive Perinatal Outreach, Access for Infants and Mothers and emergency treatment for out-of-county indigent patient programs.

- *Arizona* set aside $17 million each year from lottery revenues to fund six health and nutrition programs including Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases.

- *Louisiana* requested the Commission on Perinatal Care and Prevention of Infant Mortality to invite the secretary of the Department of Social Services and the superintendent of the state Department of Education to the commission meetings.

- Certified nurse-midwives are included as primary care providers in *West Virginia*. *Arizona* required the Arizona Health Care Cost Containment System to apply for a federal waiver to reimburse licensed midwives.

- *Iowa* appropriated funds for the Department of Public Health for several programs, including the Healthy Family Program, which provides prenatal care, infant mortality and morbidity prevention, child protection, resource mothers to assist pregnant and postpartum women and hospital-based childbirth screening to determine high-risk families. *Illinois* formed a new Department of Human Services that will provide support services to pregnant women and addicted pregnant women and work to reduce infant mortality.

- *Michigan* appropriated funds to the Department of Community Health to require HMOs and clinics in contract agreements to provide patient data, including immunizations, early and periodic screenings, diagnoses and treatments, substance abuse services and maternal and infant support services referrals.

- *Tennessee* required the TennCare Bureau to file a report with data about health care provided to women, including the incidence of early prenatal care. The special joint committee to study women's health issues in Tennessee is continued for two years to further study and make recommendations on women's health issues, including prenatal care.

- Health plans in *Tennessee* that provide coverage for pregnancy or maternity benefits may not cancel an enrollee's coverage due to pregnancy. *Utah* required that insurers cover the prenatal or maternity expenses of a birth mother if the child is placed for adoption with the insured within 30 days of the child's birth.

- *New York* allowed pregnant women to choose not to participate in mandatory managed care enrollment if they are in an established relationship with a comprehensive prenatal care provider that is not in a managed care program. Pregnant women who lose Medicaid eligibility due to income are granted a limited extension of benefits.

- Penalties for battery are increased in *Idaho* if the victim is pregnant.

- *Delaware* required health care providers to advise pregnant women of the value of HIV testing and request them to give informed consent to be tested. *Florida* required doctors and midwives to offer HIV testing to all pregnant women and offered immunity to caregivers who offered testing but were refused if the child contracts HIV. *Hawaii* requested that the Department of Health form a working group to develop a plan to ensure that HIV education, counseling and testing is offered to women of childbearing age.

Preventive and Primary Care

States continue to address preventive and primary health care issues, which are becoming more visible as the nation shifts health care services to more integrated delivery systems and to managed care. In 1996, states showed an interest in responding to the primary care demands of a managed care environment and the special health care needs of low-income, underserved and vulnerable populations. Other state primary care initiatives are contained in the access and reform, financing, insurance and managed care, medicaid, minority health, pharmaceuticals, providers and women's health sections.

- Several states—including *California, Hawaii, Massachusetts, Maine, Minnesota, New York* and *Pennsylvania*—addressed public health services.

- Community health centers and other community provider issues were the subject of legislation in *Arizona, California,* the *District of Columbia, Maryland, Nebraska, New Hampshire, Pennsylvania* and *Rhode Island.*

- *Arizona, Maryland, New Hampshire, New York* and *Pennsylvania* adopted laws dealing with medical practice in underserved areas.

- *Arizona's* ballot initiative earmarked lottery funds for several primary and preventive care issues, including low-birthweight (also addressed by *California*), preventive care, nutrition and giving families a "healthy start" with support services for families with infants and young children (also addressed in *Iowa* and *Tennessee*).

- *Florida, New Hampshire* and *Tennessee* adopted laws dealing with early intervention issues.

- *Connecticut* and *Utah* addressed postural screenings for school children and *Mississippi* established a student vision screening program.

- *Maryland* required that an assessment be developed of the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured.

- *Delaware* passed a resolution dealing with both public education and school-based education about preventing cancer and other chronic diseases.

- *California* extended family planning benefits to women who would otherwise lose benefits under Medi-Cal, the state's Medicaid program.

- *Tennessee* continued its special joint committee on women's health that deals with a number of preventive and primary care issues.

- *Kentucky* reauthorized its Commission on Poverty to evaluate the ability of existing programs to mitigate the causes of poverty. *Maryland* assisted Baltimore with a building used to provide primary care and other services to homeless people.

- *New Hampshire* expanded its drug-free school zones to Head Start centers and *Rhode Island* added public parks and playgrounds to areas where enhanced penalties for drug distribution will be imposed.

Providers

States recognize their critical role in shaping the health care workforce in today's changing health system. States are responding to marketplace demands through regulatory reform, educational institution directives and provision of direct and indirect financial incentives to providers and potential providers.

- Several states—including *Alaska, Arizona, Delaware, Iowa, Kentucky, Maryland, Minnesota, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Pennsylvania, South Dakota, Utah* and *Virginia*—enacted legislation concerning student loans for medical professionals, incentives to practice in underserved areas and volunteer doctors. *Maine* directed the Department of Health to convene a health workforce forum to discuss workforce issues.

- Laws allowing women to obtain access to obstetricians and gynecologists as primary care providers were passed in *Alabama, Arizona, Colorado, Connecticut, Georgia, Illinois, Indiana, Maine* and *Maryland.*

- A number of states—including *Alaska, California, Connecticut, Florida, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, New Hampshire, Ohio, Oregon, Rhode Island, South Dakota, Tennessee, Utah* and *Virginia*—adopted laws concerning practice parameters for physician assistants, nurse practitioners and other allied health professionals.

- *Arizona, California, Colorado, Maine, Ohio, South Dakota* and *Vermont* passed legislation addressing nurse midwives or other birth assistants.

- Several states—including *Colorado, Florida, Hawaii, Nebraska, Oklahoma* and *South Carolina*—addressed the conversion of hospitals from public to nonprofit status or from nonprofit to for-profit status. Other states—including *California, Hawaii, Idaho, Mississippi, North Carolina* and *New Jersey*—dealt with public hospital issues. California and Florida also addressed hospitals and public health functions.

- *Florida* passed a law concerning state regulatory boards for health professionals and several states and one territory addressed specific professionals, including nurses (*Hawaii*), optometrists (*California, Guam, Hawaii* and *Maine*), chiropractors (*Florida, Kentucky* and *West Virginia*), pharmacies or pharmacists (*Guam, Ohio* and *Tennessee*), dentists (*Kansas* and *Pennsylvania*), naturopathic practitioners or acupuncturists (*Maine* and *Vermont*), massage therapists (*Virginia*), osteopathic physicians (*Florida* and *Tennessee*) and personal care service providers (*Oklahoma*).

- A few states addressed regulating facilities, including birthing centers (*Tennessee*), ambulatory surgical centers (*New Hampshire*), nursing homes (*Oklahoma*) and community programs for children with disabilities (a *New Mexico* study).

- *Tennessee* legislation called for training providers in women's health issues and *New Mexico* called for a study of provider training for HIV and other infectious diseases.

- *Kentucky* repealed its parameters for clinical practice adopted in its major health reform package in 1994, and passed a law to phase out its provider tax. *Maine* enacted a data collection and uniform reporting law. *Massachusetts* addressed clinical quality improvement.

- *Georgia* adopted "prudent layperson" language in assessing whether emergency services will be reimbursed, and *Maryland* addressed emergency services regulation. *Illinois* and *Indiana* passed laws protecting "good Samaritans" who render medical care.

- *California* amended its Physician Ownership and Referral Act concerning health care referrals to people or entities in which the referring professional has a financial interest. *Washington* allowed certain health professionals to form single professional service corporations.
- *Wisconsin* created a Council on Health Care Fraud and Abuse.
- *California* addressed allowing providers from other states to practice medicine across state lines. *Maryland* made it easier for certain physicians licensed in Canada to practice in Maryland.
- *Nebraska* and *New Hampshire* passed laws to provide exemption from certain regulations for community health clinics.

Rural Health

Rural health issues continue to concern state legislatures as they address health access issues in their states. Major issues include recruiting and retaining medical professionals and addressing other access issues such as proximity of services and access to emergency services.

- *Arizona* and *Delaware* passed laws addressing recruitment of health providers into either service in rural and underserved areas or medical school. *Minnesota* provided funding for continued development of the University of Minnesota-Duluth medical school as a rural health center that aims to produce more medical professionals to serve rural areas.
- *Arizona* extended the board of medical student loans and added to its duties the responsibility to collect and maintain data on the retention of doctors who practice in rural and other medically underserved areas.
- *Florida* clarified that the Palm Beach County Health Care District's authority includes functions that promote the efficiencies of local and regional trauma agencies, rural health networks and cooperative health care delivery systems.
- *New Mexico* plans to study the feasibility of expanded emergency medical services in rural, medically underserved communities in the state as one major asset to be included in any managed care plans for the area.
- *Tennessee* wants its new Center of Excellence of Women's Health to serve as a national model for women's health in research, prevention and service by providing statewide education efforts in rural and underserved areas.
- *West Virginia* added sections to its HMO act, including one on rural HMOs, and directed the commissioner of insurance to develop a proposal for legislation providing standards for the development and operation of rural HMOs to be considered during the 1997 regular session.

School Health

Previous editions of this publication contained a more comprehensive section on school health issues. Most school health issues now are covered in NCSL's publication on adolescent health issues, *Adolescent Health Legislation: State Actions*. This publication contains a few acts related to providing health services to students, with a focus on those in grade schools.

- *Florida, Michigan* and *Virginia* passed legislation concerning Medicaid reimbursement for services provided to eligible children under special education.
- *Connecticut* and *Utah* addressed postural screening, and *Mississippi* established a student vision screening program.

- A few states--including *Delaware, Hawaii* and *Virginia*--passed laws concerning school-based health centers. *Florida* restricted school personnel from providing (or referring for) contraceptive services without parental consent.

- *New Hampshire* added physician assistants and nurse practitioners to the professionals who may perform physical exams on students, and *Michigan* passed legislation specifying that physical exams may not be compulsory.

- *New Mexico* and *Utah* passed laws concerning school nurses. *Florida* addressed training school staff to administer medicines to pupils and also addressed whether school personnel or medical professionals should perform certain other procedures needed by students.

- *Delaware* called for student education to reduce tobacco use among youth and to help prevent cancer and other chronic diseases. *Florida* prohibited smoking on school property.

Special Health Care Needs and Diseases

Between 10 percent and 15 percent of American children have a chronic health condition, about 5 percent have serious health care needs, and between 1percent and 2 percent have severe impairments that may require special medical and other support services throughout their lives. Insurance mandates related to coverage of specific conditions are include in the insurance section.

- *Colorado* authorized a statewide pilot program to allow people with disabilities to self-direct their home attendant support. Colorado also expanded the residential child health care program to include services to children with developmental disabilities who are neglected or dependent. *Indiana* created the family subsidy program account to provide flexible funding for families that care for members with disabilities at home.

- *Kentucky* required that anyone with a disability or a member of that person's family be included in the membership of each advisory board, committee, task force or ad hoc committee, that is created to develop or oversee policies or programs related to people with disabilities. *Utah* required that family support services be offered in the form of vouchers to be used by people with disabilities. *Iowa* required its Comprehensive Family Support Program to coordinate its programs for people with disabilities to ensure a choice of services and to develop a contract for direct payment using vouchers.

- *Louisiana* allowed a credit on state taxes for people who care for one or more dependents who are physically or mentally incapable for caring of themselves.

- *New Mexico* requested a study on professional licensure for personnel in community programs that serve young children with developmental disabilities.

- *Mississippi* and *Tennessee* addressed services for people with spinal cord or traumatic brain injuries.

- *Connecticut* and *South Carolina* passed early intervention laws. *Florida* designated an early intervention awareness month. *New Hampshire* established a committee to study the feasibility of requiring insurers to cover early intervention services.

- States passed laws concerning a variety of diseases and conditions to address detection or treatment needs, which are included in the insurance section.

- *Florida* and *Kentucky* adopted legislation concerning autism and *Alabama* and *Florida* addressed sickle cell disease.

- *New Jersey* provided that each local school district that participates in the Special Education Medicaid Initiative receive a percentage of the federal revenue yields for that year. In *Florida*,

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school districts are required to include in school health services plans a procedure to provide training to administer prescribed medication to students.

- Several states passed legislation concerning managed care and people with special health care needs, which are covered under insurance and Medicaid.
- *Florida* established the Children's Medical Services alternative service network to serve children with special health care needs who participate in the Children's Medical Services program.

Substance Abuse (Women and Infants)

Maternal substance abuse can harm an unborn baby. States continue to debate how to prevent damage to infants, while protecting the rights of pregnant women.

- *New Hampshire* allowed methadone to be prescribed to pregnant and postpartum heroin addicts and administered as part of an alcohol and drug abuse treatment program.
- *Arizona* established a 17-member Implementation Oversight Committee on perinatal substance abuse to advise the Department of Health Services on the implementation of the recommendations of the Advisory Council on Perinatal Substance Abuse (a 1995 interim committee). *Illinois* directed the newly created Department of Human Services to have responsibility for addicted pregnant women.
- *Michigan* added to its child abuse reporting requirements that a person who suspects that a newborn infant has been exposed to alcohol or drugs must report the suspicion to the Family Independence Agency. *Wisconsin* removed foster care workers from the list of people who are allowed to refer an infant to a doctor for testing for drugs due to the mother's use of drugs during pregnancy.
- *Iowa* required the director of public health to use the state's Commission on Substance Abuse to study the affects of fetal alcohol syndrome on children and the issues associated with removal of a child based on the parent's substance abuse. Iowa also modified a provision in the law that prohibits the use of a positive drug or alcohol test in the criminal prosecution of a mother who exposed her child to a substance perinatally.
- *Illinois* directed the Department of Public Aid, in cooperation with the departments of Alcoholism and Substance Abuse and Public Health, to provide information, through a public awareness campaign, about treatment for alcoholism and drug abuse and addiction. The program is aimed at reducing the number of drug-affected infants born to recipients of medical assistance.

Telemedicine

As technological advances enable medical services relating to diagnosis and treatment decisions to be transmitted electronically, more states are realizing that telemedicine can help address both access and provider education issues.

- *Arizona* enacted a telemedicine chapter to regulate the practice of medicine by using telemedicine technology.
- *California* and *Connecticut* enacted legislation addressing the practice of medicine across state lines. *Indiana* amended its definition of the practice of medicine or osteopathic medicine to include providing diagnostic or treatment services to someone in Indiana when those services are transmitted through electronic communications and meet certain time requirements.
- *Arizona* appropriated $1.2 million for the telemedicine network at the University of Arizona.

- *Georgia* and *West Virginia* laws addressed distance learning networks. *New Mexico* requested a study of telecommunications laws and regulations as they affect programs for distance learning, telemedicine, and access to information and public services.

- *California* enacted the Telemedicine Development Act of 1996, which prohibits health insurers from requiring face-to-face contact between a health care provider and patient for services provided through telemedicine, with some limitations.

Women's Health

More states appear to be considering the unique needs of women as women's health issues gain more national attention. This publication includes legislation that addresses women's health beyond the more narrow reproductive issues related to maternity.

- Several states—including *Delaware, Florida, Oklahoma, Tennessee* and *West Virginia*—enacted osteoporosis prevention and treatment acts. Oklahoma required insurance plans to provide coverage for bone-density testing for people at risk for osteoporosis when recommended by a primary care physician. *Tennessee* allowed bone density tests, but did not mandate them.

- *Tennessee* required the TennCare Bureau to file a report with data about health care—including prenatal care—provided to women. The special joint committee to study women's health issues in Tennessee is continued for two years to further study and make recommendations about women's health issues.

- *Delaware* required that health care providers advise pregnant women of the value of HIV testing and request that each pregnant woman give informed consent to be tested. *Florida* required doctors and midwives to offer HIV testing to all pregnant women and offered immunity to caregivers who offered testing but were refused if the child contracts HIV. *Hawaii* requested that the Department of Health form a working group to develop a plan to ensure that HIV education, counseling and testing is offered to women of childbearing age.

- Several states—including *California, Rhode Island* and *Wisconsin*—enacted legislation banning female genital mutilation. *Louisiana* urged Congress and the president to use their influence in international relations to end the practice.

- *Maryland* required hospitals to offer mammography educational materials to female patients. *California* directed the Department of Health Services to establish two levels of registration fees for mammography equipment.

- Several states enacted laws to require health insurance plans to cover treatments for certain conditions, including *Alaska, Maine* and *Virginia* (cervical cancer screening), *Kentucky* (bone marrow transplants for treatment of breast cancer) *Maryland* and *Rhode Island* (breast reconstruction after mastectomy) and *Oklahoma* (osteoporosis screening). *Connecticut* prohibits health plans from refusing to cover an applicant who once suffered from breast cancer under certain conditions and exempts follow-up breast cancer examinations from preexisting condition exclusions.

- *Connecticut* passed laws concerning breast and cervical cancer detection and treatment. *Delaware* and *New York* established breast cancer education funds created with income tax checkoffs. *Florida* designated a Breast Cancer Awareness Month. *Oklahoma* authorized specialized license plates to publicize the fight against breast cancer.

- *California* established a program to provide an additional three years of family planning services to people whose incomes are below the poverty level, who have no other health care coverage and who are not eligible for Medi-Cal services.

- *Tennessee* required health care providers who know or suspect that a patient's injuries are due to domestic violence to make a report to a local law enforcement agency.

ACCESS AND REFORM

AL **1996 Ala. Acts, H. Jt. Res. 69** creates a joint interim committee composed of three members of each house to study all facets concerning the acquisition, maintenance, allocation and structure of service delivery associated with federal block grants and major program reforms proposed by the United States president and Congress. The committee must report to the legislature by the 20th legislative day of the 1997 regular session, at which time the committee will be dissolved unless continued by a joint resolution.

AZ **1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)** changes the name of the medically needy and medically indigent program stabilization fund to the medical services stabilization fund. The act expands the use of money in the stabilization fund to be used to offset increases in the cost of providing levels of services to those eligible for Arizona Health Care Cost Containment System (AHCCCS) services through federal categories if the increase in costs is caused by a decrease in federal funding. The act makes a one-time transfer of $30 million from the medically needy account to the medical services stabilization fund.

Subject to the availability of funds in the medically needy account of the tobacco tax and health care fund, the act establishes the premium sharing demonstration project fund and the basic children's medical services program. The AHCCCS administration, contingent on the existence of the fund, is authorized to withdraw $20 million in FY 1996-97, 1997-98 and 1998-99 to be deposited in the fund to provide health care services to those eligible for the AHCCCS Premium Sharing Demonstration Project Implementation Committee to make recommendations to the governor, the Legislature, the secretary of state and the director of the Arizona Legislative Council by November 15, 1996, regarding the implementation of a premium sharing program. The act recommends that the committee address participant eligibility criteria, an income threshold that does not exceed 300 percent of the federal poverty level, the types of services to be provided and the entity that should be responsible for collecting participant premiums. At the direction of the committee, the AHCCCS administration is required to conduct actuarial studies that provide rate and premium sharing cost estimates.

Beginning FY 1996-97, the act annually transfers up to $5 million to the Department of Health Services (DHS) to establish contracts with eligible hospitals to provide for a basic children's medical services (BCMS) program, to provide health care services to indigent, uninsured or underinsured children who are not eligible for AHCCCS services. Up to two percent of the total funding is authorized to be used for administrative costs and additional money, as necessary, to perform program evaluations. Program money is required to be used to enhance the hospital's ability to provide additional services to eligible children and improve the delivery of inpatient, outpatient and specialized clinical services. The act sets out requirements for participating hospitals, including a sliding fee scale for eligible children. DHS is exempt from rule making requirements for the implementation of this program.

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. For most AHCCCS recipients, the federal government pays 65 percent and the state pays 35 percent of the costs of health care. Currently, there are many eligibility categories that determine whether an individual can receive health care under AHCCCS, including one requiring that a recipient's net income not exceed approximately 34 percent of the "federal poverty level." Proposition 203 expands eligibility to cover people who earn up to 100 percent of the federal poverty level under AHCCCS.

Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, to be allocated as follows: $5 million to the Healthy Families Program, which provides services to prevent child abuse and neglect and to promote child wellness and proper development; $4 million to the Arizona Health Education System to provide scholarships to medical students who agree to practice in areas of the state that are currently underserved by health care professionals; $3 million to programs to prevent teenage pregnancy; $2 million for disease control research; $2 million to Healthy Start, a program that aims to reduce the incidence of low-birth-weight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children; and $1 million to the Women, Infants and Children Food Program.

Previously, lottery revenues were earmarked for deposit in economic development, local transportation assistance and two state heritage funds. Under Proposition 203, the $17 million will be distributed only after the economic development, local transportation assistance and heritage funds receive their full appropriations.

CA **1996 Cal. Stats., Chap. 954 (SB 38)** conforms with federal law allowing small employers and self-employed individuals to create medical savings accounts.

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the following programs funded by Cigarette and Tobacco Products Surtax Fund money: Comprehensive Perinatal Outreach, selected primary care clinics, Access for Infants and Mothers, County Medical Services Program and emergency treatment of out-of-county indigent patients. The act revises reporting and maintenance of effort requirements under the California Health Care for the Indigent Program.

CA **1996 Cal. Stats., Chap. 864 (SB 1665)** enacts the Telemedicine Development Act of 1996, which sets standards for the use of telemedicine by health care practitioners and insurers. The act prohibits health insurers from requiring face-to-face contact between a health care provider and patient for services appropriately provided through telemedicine, subject to the terms of the contract.

CA **1996 Cal. Stats., Chap. 902 (SB 2098)** authorizes the Medical Board of California to develop a proposed registration program that would permit physicians, surgeons and podiatrists located outside the state to practice medicine across state lines and requires them to meet the legal requirements of the state.

CA **1996 Cal. Stats., Chap. 1012 (AB 2577)** allows San Luis Obispo County to close its county hospital emergency room and contract with non-county hospitals for emergency room services without risk of losing state funding for indigent health care.

CT **1996 Conn. Acts, P.A. 96-238 (SB 72)** requires the Department of Public Health (DPH) and the Office of Health Care Access (OHCA), consulting with the Department of Social Services (DSS), to establish a five-year demonstration project to improve access to health care in an area where the viability of traditional acute care hospitals is in question. These agencies must jointly select one hospital willing to terminate its certificate of need (CON) as an acute care hospital and its license as an inpatient hospital. The selected facility must provide an emergency room that must be affiliated with a hospital and uses paramedics, or an ambulatory surgery center.

Under the act, the facility also may provide nursing facility beds if they represent a portion of beds already licensed and occupied as of June 4, 1996, if those nursing beds are relocated from an existing Medicaid-certified nursing facility and the relocation does not result in increased state expenditures and increased nursing beds in the state. The facility also may provide assisted living under a continuing care facility guaranteeing life care for its residents. By January 1, 2001, DPH, DSS and OHCA must report to the Public Health and Human Services committees on the effect on access to health care in the area of the state selected for the project.

DC **1996 D.C. Stats., Act 11-486 (Bill No. 11-962)** amends, on an emergency basis due to congressional review, the Free Clinic Assistance Program Act of 1986 to extend the life of the program until September 23, 2001.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** strengthens the Agency for Health Care Administration's (AHCA) ability to regulate Medicaid HMOs in response to concerns about marketing and enrollment abuses, quality of care problems and reimbursement improprieties. (See Medicaid for more information.)

The act also establishes the Children's Medical Services alternative service network to serve children with special health care needs and children who participate in the Children's Medical Services Program. (See "Special Health Care Needs" for more information.)

In addition, the act authorizes a study of alternative service networks. Within existing resources, AHCA is directed to work with the Department of Insurance, the Department of Health and Rehabilitative Services, the Department of Education, the Department of Elderly Affairs and provider groups to study the feasibility of non-risk-bearing alternative service networks for Medicaid recipients, possibly using the Children's Medical Services network as a model. An interim report is due to the governor and the chairpersons of the Appropriations and Health Care Committees of each chamber of the Legislature by January 1, 1997 and a final report by January 1, 1998. Finally, the act requires the Department of Insurance (DOI) to establish actuarially sound medical loss ratios for Medicaid and details numerous licensure provisions relating to the DOI, including increased fines for HMOs that violate DOI licensure requirements.

FL **1996 Fla. Laws, Chap. 319 (SB 14)** extends COBRA to employers with fewer than 20 employees. The act also establishes the Florida Health Insurance Coverage Continuation Act which provides for continuation of coverage for 18 months from the qualifying event, with the employee or dependent paying 115 percent of the applicable premium. The employer does not pay any of the cost for the continuation of coverage. The carrier is responsible for one mailing per household of any required document. The employee must elect coverage and pay the premium within 30 days of receiving the election form and premium notice from the carrier. The carrier can contract with the employer to perform the administrative duties of this act and the employer can, with the carrier's approval, delegate those duties to an entity.

FL **1996 Fla. Laws, Chap. 337 (HB 1813)** renames the Florida Healthy Kids Corporation Act the "William G. 'Doc' Myers Healthy Kids Corporation Act" and removes language that limited the program from operating at no more than 10 sites on a pilot basis. Amended language allows the program to designate sites without legislative approval and limits program services to children.

FL **1996 Fla. Laws, Chap. 403 (HB 555)** establishes the Public Health and Health Care Administration Act of 1996. The act creates a new agency, the Department of Health (DOH) to serve as the single state agency responsible for all health matters for which the state has authority. The act transfers the Agency for Health Care Administration, the Agency for Public Health Services and the Division of Medical Quality Assurances to DOH. The act transfers the duties of the Department of Health and Rehabilitative Services, Children's Medical Services Program Office and the Alcohol, Drug Abuse and Mental Health Program Office to the Agency for Public Health Services. The act transfers the duties of the Health Care Board to the Agency for Health Care Administration, effective October 1, 1997. The act authorizes the DOH to establish uniform application forms and certificates of licensure for use by the boards within the department. Each board with five or more members is required to have at least two consumer members who are not and have never been, members of the profession regulated by the board. Boards with fewer than five members must have at least one consumer member outside of the profession.

Finally, the act creates a task force to make recommendations on the structure and organization of publicly funded health-related programs and agencies; the organizational placement of health facility and health care practitioner regulation that will ensure the highest quality of health care; the role and mission of local and state agencies with public health care functions; methods for coordinating health services delivery with health care financing, policy, purchasing and regulatory requirements; and the advantages and disadvantages of centralizing health care administration and accountability. A report is due to the governor and Legislature by December 31, 1996.

GU **1996 Guam Laws, P.L. 23-35** establishes a means test for the Medically Indigent Program (MIP) that includes a client cost sharing program. (MIP is 100 percent locally funded.)

HI **1996 Hawaii Sess. Laws, S. Res. 147** requests the Public Utilities Commission (PUC) to submit a report to the Legislature by September 30, 1996 detailing the manner in which it is expanding access to advance telecommunications services on a statewide basis, especially on the neighbor islands during 1996 and 1997. The act requests that PUC include in its report a timetable listing the potential telecommunications providers seeking to provide basic and advanced services throughout the state and identifying those areas determined by the commission to be underserved.

ID **1996 Idaho Sess. Laws, Chap. 59 (HB 446)** amends existing law to exempt from the definition of salary for Public Employee Retirement System purposes any employer contributions to an employee's medical savings account up to a certain amount.

ID **1996 Idaho Sess. Laws, Chap. 60 (HB 502)** amends existing law on medical savings accounts to correctly define terms, provide that service charges are not withdrawals from the account, require nontaxable reimbursements to be made within the time specified, allow reversal of erroneous deposits within 30 days, provide rollover of funds to another account without tax consequences if made within 60 days and clarify depository reporting requirements.

ID **1996 Idaho Sess. Laws, Chap. 410 (SB 1567)** repeals and amends certain sections relating to care for the medically indigent. The act specifies the power and duty of the Board of County Commissioners to provide for the care of medically indigent residents of the county and to provide certain emergency care for nonresidents for the period between July 1, 1996 and June 30, 1997. The act specifies duties of the administrator and authorizes reciprocal agreements with other states. The act provides for a written application for financial assistance and to provide a lien upon application and a schedule to govern the investigation of an application or request. In addition, the act provides a petition for judicial review of a final determination and requires notification of admission and to authorize transfer of a medically indigent person. The act governs the amount to be paid for necessary medical services and to provide for repayment of amounts collected. The act specifies the right of subrogation for the county and the catastrophic health care costs program and the right to govern the method for reimbursement of financial assistance.

ID **1996 Idaho Sess. Laws, H. Concur. Res. 45** directs the Department of Administration to solicit at least three bids for establishing a medical savings account program for health care coverage for state employees. The program must be comparable in quality to the current health care plan providing for an annual deductible limit of $110 and also must provide annual deductible limits of $2,000 for an individual, $2,500 for a two-person household, $3,000 for a family and no copayment after annual deductibles are met.

IL **1996 Ill. Laws, P.A. 89-486 (HB 3186)** changes the Comprehensive Health Insurance Plan (CHIP) to restrict "optional family coverage" to members of the household of a person insured by CHIP only if they meet the criteria for regular eligibility. (Previous law made all members eligible for CHIP if one member qualified.) Rates for optional family coverage and deductible and coinsurance amounts, are to be set by the CHIP board. People buying waivers of the preexisting conditions exclusion need pay the required surcharge of up to 10 percent for only 60 months instead of indefinitely.

IL **1996 Ill. Laws, P.A. 89-628 (HB 3520)** allows the Comprehensive Health Insurance Plan (CHIP) to discount or subsidize premiums for elderly, retired, or unemployed participants if funds allow.

IL **1996 Ill. Laws, P.A. 89-646 (SB 1513)** amends the Public Aid Code to provide that a local governmental unit in any county may elect to provide, at a minimum, under the General Assistance Program, financial aid for emergency medical treatment, care and supplies only, deleting the term "necessary treatment, care and supplies required because of illness or disability." The act requires that the General Assistance rules of the local governmental unit must specify the emergency treatment for which financial aid is provided and must include medical treatment, care and supplies necessitated by a condition that is life-threatening, will result in significant and permanent physical impairment, or requires immediate attention to relieve significant present physical impairment, or requires immediate attention to relieve significant present physical pain and suffering. The act provides that a township, township supervisor, or township employee is not liable for injury caused by a decision to grant or deny aid under the Article on General Assistance. Allows local governments offering general assistance to choose to pay for medical care for acute illnesses only.

IL **1996 Ill. Laws, P.A. 89-667 (SB 1327)** allows the Illinois Department of Public Health to investigate a hospital in an Emergency Medical Services (EMS) system that goes on "bypass status" to determine whether that action was reasonable and to fine a hospital for unreasonably going on this status. The act also requires each EMS system and its trauma center medical directors' committee to send the department, within 90 days after enactment, an internal disaster plan describing contingency plans to transfer patients to other facilities in a catastrophe.

KY **1996 Ky. Acts, Chap. 371 (SB 343)** makes numerous changes to the comprehensive health reform legislation enacted in 1994. The act abolishes the Health Policy Board and transfers its duties to various state agencies. The health data collection is transferred to the Cabinet for Human Resources; the health insurance responsibilities are transferred to the Department of Insurance; the 24-hour coverage pilot is transferred to the Department of Insurance; and the certificate of need functions are transferred to the Cabinet for Human Resources.

The act creates a permanent advisory committee to define quality outcome measures and advise the Cabinet for Human Resources on data interpretation and publication. It also repeals the requirements that providers, hospitals and facilities conspicuously post maximum fees charged. The act repeals the requirement relating to the development, updating and implementation of parameters for clinical practice for use by health care providers. The act raises the expenditure threshold for major medical equipment from $500,000 to $1.5 million before a certificate of need is required for a physician's office.

Relating to the Health Purchasing Alliance, the act specifies that alliances are to be attached for administrative purposes to the Department of Insurance but operated independently. The act also exempts use of modified community rating issued to an association that existed before January 1, 1996; meets a statutory definition; does not deny membership on basis of health status or claims; and complies with portability, renewability, guaranteed issue and preexisting exclusion provisions. The act also permits phase in of modified community rating.

The act creates a seven-member Health Insurance Advisory Council to advise the insurance commissioner on issues that impact the provision of health insurance. It also makes several changes to insurance law including directing the commissioner to hold a hearing on every filing that contains an average rate increase that exceeds the medical price index plus 10 percent; prohibiting insurers receiving approval from submitting a new rate or fee increase for the same policies/contracts within 12 months; and permitting continuation of group coverage for 18 months rather than nine after a person terminates group membership. The act increases the preexisting exclusion from six to 12 months and maintains modified community rating, but permits use of gender (no more than a 50 percent variation from lowest to highest factor); occupation/industry (no more than a 15 percent variation); and for all case characteristics (no more than a 5 to 1 variation from highest to lowest rate factor). The act allows a 10 percent discount for healthy lifestyles.

The act also permits creation of provider sponsored networks and requires the networks to obtain a certificate of filing from the commissioner of insurance.

The act deletes the requirement that the Cabinet for Human Resources seek a federal waiver to require Medicaid recipients to pay $3 copayments on specified services; deletes the previous mandatory participation for non-institutionalized aged, blind and disabled recipients in Medicaid Managed Care; repeals the discount option program, which permitted low-income people to buy health care services at Medicaid rates; and prohibits Medicaid payment for services provided in Kentucky by an out-of-state health facility or services if the facility or services do not have a certificate of need (CON) and would otherwise be required to obtain a CON if located in Kentucky.

LA **1996 La. Acts, P.A. 11 (HB 200)** allows a deduction from taxable income for contributions to a medical savings account, not to exceed the allowable deduction for a qualified higher deductible health plan. The act sets the deductible level at $1,250 to $2,500 for individual health coverage and $1,750 to $3,500 for an individual and his/her dependents. The act provides for adjusting the deductible limits annually for increases in the cost of living, as measured by the medical costs component of the Consumer Price Index. The act authorizes each employer to voluntarily offer continued coverage under the employer's existing health coverage and participation in a medical savings account program. The act authorizes an employer that previously did not grant accident and health insurance coverage under any other health plan, including an HMO, to establish a medical savings account program. The act also authorizes resident individuals to establish a medical savings account for the benefit of themselves or their dependents.

ME **1996 Maine Laws, Chap. 598 (LD 1722)** enables establishment of a nonprofit corporation known as the Maine Center for Public Health Practice to plan, promote and coordinate health services research, training and policy efforts utilizing a consortium of public and private organizations within the state, including the public university system. The center's research and demonstration efforts may include the cause, effects, extent and nature of illness and disability among all or a particular group of people of the state, the impact of personal illness and disability on the state economy, the quality and availability of health resources, access to and use of health care services by all or a particular group of people, including the use of ambulatory health care services and public health policies and programs.

ME **1996 Maine Laws, Chap. 653 (LD 1788)** creates the Maine Health Data Organization (MHDO) to continue the data collection efforts of the Maine Health Care Finance Commission, which expired on June 10, 1996. The act provides for the establishment of and duties of the MHDO governing board, with board members representing consumers, employers, payers and providers.

The act directs the board to establish uniform reporting systems. The board must develop and implement data collection policies and procedures for the collection, processing, storage and analysis of clinical, financial and restructuring data. The act directs the board to integrate data systems, standardize concepts and coordinate the development of a linked public and private sector information system. The board must emphasize data that is relevant and not duplicative of existing data and minimize the burden on those providing data. In addition, the board is directed to preserve the accuracy of collected data while ensuring that the data are available in the public domain. The act retains current requirements for information to be submitted by facilities, providers and payers. The act provides for confidentiality, use of data for research purposes and access to aggregate data.

To finance the Maine Health Data Organization during the transition, the act allows all hospitals except state hospitals to be assessed not more than .07 percent of their gross patient revenues, not to exceed $775,000 for all hospitals. Each hospital must pay the assessment quarterly. The act requires the board to submit legislation to establish fees and assessments for permanent funding.

In order to conduct quality improvement research, the board is authorized to designate a quality improvement foundation if the board finds that the foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and has protocols to safeguard confidential and privileged information.

The act amends and reenacts provisions governing comprehensive health planning. The act requires that the Department of Health adopt a state health plan before January 15, 1997 and review it every year after 1997. The plan must identify the state's health care, facility and human resource needs, the resources available to meet those needs and recommendations for addressing those needs statewide.

The act directs the Department of Health to adopt reasonable charity care guidelines for hospitals. The department must adopt income guidelines that are consistent with the guidelines applicable to the federal Hill-Burton Program. The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. The guidelines must include provisions for notice to the public and the opportunity for a fair hearing regarding eligibility for charity care.

The act directs the Department of Health to convene at least once annually a health workforce forum to discuss health workforce issues. The forum must include representatives of health professionals, licensing boards and health education programs. The act directs the forum to develop an inventory of present health workforce and educational programs and develop research and analytical methods for understanding population-based health care needs on an ongoing basis. Through the forum, the department is to serve as a clearinghouse for information relating to health workforce issues. The department will use the information gathered through the forum to make its health policy and planning decisions.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** creates the Maine Health Care Reform Act of 1996, which institutes health plan improvements and provides for the creation of private purchasing alliances. The act creates a licensing and regulatory process to allow the establishment of private purchasing alliances in Part A. Private purchasing alliances are nonprofit corporations licensed by the Bureau of Insurance to provide health insurance to members through multiple unaffiliated participating carriers. When established, an alliance must offer a range of health plans from at least three different carriers within the alliance's service area. One of these health plans must be a catastrophic plan providing coverage for inpatient hospital benefits only.

In Part B, the act extends the continuity of coverage protection for people eligible for unemployment compensation from 90 days to 180 days and requires the Bureau of Insurance to set standards distinguishing excess insurance from basic insurance. Part C deals with managed care regulation. (See the "Insurance" chapter for a detailed summary of Part C.)

MD **1996 Md. Laws, Chap. 335 (HB 1330)** creates a state debt not to exceed $100,000 with a matching fund requirement as a grant to the board of directors of Health Care for the Homeless Inc. for the repair, renovation and equipping of a building in Baltimore City that is used as a support center for the homeless where physical and mental health care, crisis intervention and other services are provided. Improvements include installation of a new elevator, renovation of the heating, ventilation and air conditioning systems and other capital repair.

MD **1996 Md. Laws, Chap. 549 (HB 1390)** requires the Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review Commission, to assess the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The act also directs the commission to examine the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. A report on the results of the commission's investigation, together with any resulting policy recommendations, is due on or before November 1, 1996.

MA **1996 Mass. Acts, Chap. 147 (HB 6004)** creates a new public health commission in Cambridge to replace the city's Department of Health and Hospitals in order to better administer, enhance and expand the public health services provided by the city. The new public health care system, governed by a new Cambridge Public Health Commission, is to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation and long-term care services in order to create a comprehensive and integrated continuum of care with the goals of promoting health and well-being of all in the system's service area. The commission must file with the city manager and city clerk an annual assessment of the city's public health needs by January 15 each year.

The new public health system is to be committed to the provision of excellent and accessible health services to the community, including programs that are responsive to the multicultural and multilingual composition of the service area and to the particular needs of specific populations, including women and children, adolescents, minorities, the elderly and people at high risk for health problems.

MA **1996 Mass. Acts, Chap. 203 (HB 6107)** expands Medicaid eligibility for children under age 12 with family incomes under 200 percent of poverty. The act authorizes Medicaid benefits to be provided by means of a demonstration project known as MassHealth. The act also expands eligibility for the Children's Medical Security Plan to children from the current age 12 to 18, which covers Medicaid ineligible children on a sliding scale basis.

The act increases the cigarette tax to 25 cents per pack, which also applies to cigars and pipe tobacco, to help fund both program expansions.

The act also establishes a program of pharmacy assistance for certain people with disabilities and elderly people who are not eligible for medical assistance or other third-party coverage for pharmacy benefits.

MA **1996 Mass. Acts, Chap. 338 (HB 5478)** directs the Department of Public Health, after public hearings, to promulgate regulations for the licensing and conduct of specialized health care facilities for the homeless. These facilities will provide homeless individuals with inpatient medical and nursing care and rehabilitative care, together with social and other multi-disciplinary services. Under the act, the department may issue two-year licenses to qualified entities, with a two-year renewal. The licenses are subject to suspension, revocation, or refusal to renew for cause.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following:

The act creates an integrated state-level health delivery system for those in need of state services by combining most of the funding and functions of the Department of Mental Health, the Department of Public Health and Medicaid into a single organization.

From the funds appropriated for the indigent medical care program, the department must establish a program that provides for the basic health care needs of indigent people and eligibility for the program is limited to the following: people currently receiving cash grants under either the family independence program or state disability assistance programs who are not eligible for any other public or private health care coverage; and any other resident of the state who currently meets the income and asset requirements for the state disability assistance program and is not eligible for any other public or private health care coverage. The program must provide for the following minimum level of services for enrolled individuals: physician services provided in private, clinic, or outpatient office settings; diagnostic laboratory and x-ray services; and pharmaceutical services.

The act authorizes the Department of Community Health, in cooperation with the Family Independence Agency, to establish a pilot project for those who work their way off welfare to purchase Medicaid coverage at a rate determined by the department. The department may receive and expend premiums for the buy-in of Medicaid coverage in addition to the amounts appropriated in this act.

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MS **1996 Miss. Laws, Chap. 491 (H 1057)** authorizes the Department of Finance and Administration to offer medical savings accounts as a plan option for health insurance coverage for state and public school employees after January 1, 1998. before offering such accounts as a plan option, the act directs the department to prepare and present to the Senate and House Insurance Committees by December 15, 1996, a comprehensive study, including a proposed implementation timetable and potential actuarial effects of such accounts on the existing state employee health plan. The study must include recommendations on employer and employee contribution levels, annual rollover of balances or withdrawals for nonmedical purposes and medical coverage for people who expend their account balances.

MS **1996 Miss. Laws, Chap. 496 (H 1187)** amends current law to specify that all University of Mississippi Medical Center locations provide not less than 50 percent of their services to indigent people, including qualified beneficiaries of the state Medicaid Program. The act also authorizes the teaching hospital and related facilities to establish and operate managed care plans and to enter into group purchasing arrangements.

NJ **1996 N.J. Laws, Chap. 28 (AB 1532)** provides $310 million for indigent care payments to hospitals for 1996 and $300 million in 1997, down from $400 million that was available in 1995. Funds will still be used from the unemployment fund. The law also authorizes the commissioner of the Department of Health to submit a waiver to the federal government in order to allow New Jersey to use disproportionate share payments for a managed care-type plan for charity care. The law also funds the hospital health care subsidy account that provides payments to hospitals that treat a large amount of AIDS, TB, low-birth weight babies, drug and alcohol abuse and other public health problems. The subsidy account is funded at the same level as the last two years.

NJ **1996 N.J. Laws, Chap. 29 (AB 1590)** adds uninsured children to those eligible for Health Access New Jersey, a program that provides subsidized insurance for low-income working people and those temporarily unemployed. The act amends previous law to allocate to Health Access New Jersey $10 million in 1996 (down from $100 million) and $25 million in 1997 (down from $150 million).

NM **1996 N.M. Laws, Chap. 29 (HB 298)** amends various statutes related to county indigent health care. The County Local Option Gross Receipts Taxes Act is amended to require that funds raised from the second one-eighth and 50 percent of the third one-eighth be placed in the county indigent hospital claims fund and spent according to the Indigent Hospital and County Health Care Act. This provision will prevent the diversion of county indigent funds to non-health care related initiatives. The Statewide Health Care Act is amended to allow for funds from the nine percent set aside from the county-supported Medicaid fund to be used to support existing primary care facilities and establish new primary care facilities. The Rural Primary Health Care Act is also amended to define "eligible programs" as nonprofit community-based entities providing or committing to provide primary health care services. This change will allow communities greater flexibility to use existing entities to provide primary care services. Finally, the act extends the reversion date by two years, until 1998, for counties to transfer balances of funds from the county indigent hospital claims fund to the county-supported Medicaid fund.

NM **1996 N.M. Laws, H. Jt. Mem. 20** requests that the New Mexico Health Policy Commission, in cooperation with the Department of Health, the Human Services Department and the Department of Insurance, study and propose options to improve access to comprehensive health care by better use of existing public and private funds. The study is to include current federal, state and local fiscal resources and how they can be realigned to improve health care purchasing and delivery; publicly funded insurance programs and how restructuring can improve quality and access to insurance; roles and responsibilities of the private sector and state and local governments; processes to involve the public, advocates and providers in health care spending and benefit decisions; and how private health care dollars can be leveraged with public dollars to provide more services to the uninsured.

NM **1996 N.M. Laws, Sen. Jt. Res. 31 (SJM 31)** resolves that the Department of Health study the feasibility of expanded emergency medical services in rural, medically underserved communities throughout the state as one major asset to be included in any managed care plans for the area. The

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department is requested to report its findings to the interim legislative health and human services committee at its October 1996 meeting.

NY **1996 N.Y. Laws, Chap. 253 (S 7537-A)** indefinitely continues the child health insurance program (Child Health Plus) and the regional pilot projects for the uninsured by removing the sunset date of June 30, 1996 for each program. The act authorizes the continuation and amendment of any contractual arrangements with approved organizations to provide coverage for eligible individuals in effect on that date in order to provide an uninterrupted continuation of services. The act stipulates, however, that these programs will remain in effect only as long as funds continue to be available.

The act makes available to the commissioner of health, for distribution to these two programs, funds accumulated in pool reserves for regional or statewide pools, as well as certain funds accumulated in the health care planning account during the period January 1, 1996, to June 30, 1996. The act authorizes the commissioner, for cash flow purposes, to allocate funds accumulated for distribution from certain other specified pools to the pool reserves in order to pay the premiums for the continuation of Child Health Plus and the regional pilot projects and requires the commissioner to refund this money when pool reserve funds become available. Finally, the act extends for another year, until June 30, 1997, the excess medical malpractice liability insurance program (see Chap. 639 for other information related to the Child Health Plus Program).

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which continues only until December 31, 1996, existing provisions of the state's hospital reimbursement rate-setting law. The acts continue beyond 1996 until December 31, 1999, the same rate-setting methodology only for Medicaid and certain other payers. The acts deregulate the payment system for most other payers, on and after January 1, 1997, by allowing them to negotiate with hospitals to establish their own payment rates.

The acts establish a number of new provisions for the financing of "public goods programs" on and after January 1, 1997. Insurers and other payers must pay allowances on payments for services rendered, as well as per-person payments for each individual or family member covered by the insurer ("covered lives assessments"), which go into a pool to fund the public goods programs. Funds from these payments, as well as certain Medicaid funds and other payments, are used to finance the costs of graduate medical education, various insurance programs for the uninsured, primary care development, emergency medical services training and health facility restructuring and provider networking programs designed to assist providers in adapting to the changing health care environment.

For example, the acts authorize the commissioner of health to distribute funds in the health care initiatives pool for the Child Health Plus Program ($120 million in 1997, $164 million in 1998 and $181 million in 1999), the Small Business Health Insurance Partnership Program, the Voucher Insurance Program, the Individual Subsidy Program, the Catastrophic Health Care Expense Program, the Primary Health Care Services Pool and the Primary Care Education and Training Program (including the loans, scholarships and medical education grants for minority participation).

The acts continue and expand the Primary Care Physician Loan Repayment Program and add to the eligibility requirements for residents that they must agree to practice in underserved areas. The acts also enhance the programs efforts to encourage minority participation in medical education.

The acts create a new State Task Force on Health Care Quality Improvement and Information Systems within the Department of Health and authorize the commissioner of health to award grants to support collaborative community-based efforts to improve health status and quality of care.

The acts make permanent the Child Health Plus Program, through which primary and preventive health services are provided to eligible children, expand the program by increasing the age limit for eligibility, add coverage for hospital and related inpatient services and make several other changes.

Participating insurers must impose a copayment of $2 per visit for physician services, in addition to the other copayments and coinsurances for which insurers are permitted to require payment.

The acts increase the required family contribution toward the premium costs for children's coverage, concurrently with the addition of inpatient services on January 1, 1997, to make such payments vary based on the relationship of the family's net income to the non-farm federal poverty level (FPL), as follows: for income less than the FPL, no payments; for income 100 percent to 132 percent of FPL, payments of $9 monthly per eligible child (with a maximum per family of $36 monthly); and for income 133 percent to 185 percent of FPL, $13 monthly per eligible child (family maximum $52 monthly).

The acts establish a new program entitled the "New York State Small Business Health Insurance Partnership Program," administered by DOH, to assist eligible employers in purchasing small group health insurance or comprehensive health services plan coverage for employees and their dependents. The program applies to employers of less than 50 full-time employees (those who work at least 20 hours per week), which have not provided group health insurance benefits to any employees for the past 12 months. The acts authorize the superintendent of insurance, in conjunction with the commissioner of health, to conduct a demonstration program to assist eligible individuals and families in purchasing health care coverage from approved insurers and make this program available to individuals and families who can adequately document that: they reside in specific areas designated by the superintendent; their gross household family income does not exceed 122 percent of the non-farm federal poverty level; and they are not eligible for Medicaid or Medicare, do not have equivalent health care coverage and have not had equivalent coverage within the 12-month period before application, with exceptions. Vouchers may be provided to such individuals and families and the vouchers may then be submitted to participating insurers in order to obtain coverage.

The acts allow Rural Health Network Development Grants to be used to support activities and organizational costs, including the recruitment of qualified health care professionals, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community-based primary care systems and the integration and expansion of prehospital emergency medical services. The acts create a new "Rural Health Care Access Development Program," through which grants and financial assistance can be provided to general hospitals classified as rural hospitals under federal or state regulations, in recognition of the unique costs incurred by these facilities in providing hospital services in remote or sparsely populated areas. The acts require each hospital's performance in meeting the health care needs of the community, providing charity care services and improving access to health care services by the underserved.

NC **1996 N.C. Sess. Laws, Chap. 634 (HB 1149)** allows the N.C. Medical Board to issue to an applicant a special license called a "Limited Volunteer License," authorizing the holder to practice medicine and surgery only at clinics which specialize in the treatment of indigent patients. The holder of a limited license may not receive compensation for services rendered at these clinics. The applicant must have a medical license from another state and produce a letter from that state indicating that the applicant is in good standing and is authorized to treat U.S. armed forces personnel or veterans.

NC **1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part XVI (SB 46, Part XVI)** abolishes the North Carolina Health Care Reform Commission, effective January 1, 1997. The act also requires every occupational licensing board that has authority to license physicians, physician assistants, nurse practitioners and nurse midwives in the state to modify procedures for license renewal to include the collection of specified information for each board's regular renewal cycle. The purpose of this requirement is to assist the state in tracking the availability of health care providers to determine which areas in the state suffer from inequitable access to specific types of health services and to anticipate future health care shortages which might adversely affect the citizens of the state. The licensing boards must collect information and report and update the information on an annual basis to the Department of Human Resources, which must provide this information to programs preparing primary care physicians, physician assistants and nurse practitioners upon request by the program and by the Board of Governors of the University of North Carolina. Information provided by the occupational licensing board may be provided in such form as to omit the identity of the health care licensee.

OH **1996 Ohio Laws, H. 179** provides for the establishment, operation and administration of medical savings accounts as a method to obtain health care in conjunction with a policy, plan, or contract or health insurance coverage. The act provides Ohio income tax benefits to individuals relative to the establishment and use of medical savings accounts and authorizes the superintendent of insurance to include coordination of benefits regarding medical savings accounts in the superintendent's rules on coordination of benefits.

OK **1996 Okla. Sess. Laws, Chap. 86 (SB 999)** allows counties and municipalities to jointly create a hospital authority for the purpose of planning, financing and constructing hospital or related medical facilities. A hospital authority may levy a sales tax, not to exceed 2 percent, upon voter approval in each of the local governments comprising the authority.

OK **1996 Okla. Sess. Laws, Chap. 183 (HB 2188)** enables state employees to participate in the Oklahoma Medical Savings Account Program.

PA **1996 Pa. Laws, Act 87 (HB 216)** establishes the Office of Physician General within the Department of Health and provides that the physician general will be appointed by the governor, by and with the advice and consent of the Senate. The physician general, who must be a practicing physician, is to advise the governor and the secretary of health on health policy; participate in the decision-making process of the department on policies relating to all medical and public health-related issues and in the decision-making process of other executive branch agencies as directed by the governor, review professional standards and practices in medicine and public health; consult with recognized experts on medical and public health matters; coordinate educational, informational and other programs for the promotion of wellness, public health and related medical issues and serve as the primary advocate for such programs; and consult with experts in the state and other states regarding medical research, innovation and development.

The act requires the department to establish a 12-month review program to determine the feasibility and effectiveness of entering into contracts with local health care providers for the operation of state health centers or the provision of equivalent services. The program must utilize the equivalent services provided by three existing state health centers on the effective date of the act, one in an urban area, one in a suburban area and one in a rural area. Other than these three health centers, the act prohibits the department from entering into contracts with any additional private providers that would result in the elimination of any state health center, nor reduce the scope of services currently provided, nor reduce the number of centers. On or before December 31, 1997, the department must submit a report to the General Assembly, which shall include a review and analysis of the three health care centers or of the provision of equivalent services in the review program, including patient utilization and services provided; an analysis of the performance of each local health care provider, including patient satisfaction with the provision of services; a review of other delivery systems for health services in the community, both public and private; a comparison of the cost and effectiveness of the operation of each of the three health care centers by the commonwealth with the cost of the provision of equivalent services by local health care providers; recommendations regarding continuation of the provision of the services previously provided by the three health care centers included in the study program be local health care providers; and recommendations regarding the public and private operation of all remaining health care centers, or the provision of equivalent services, in the Commonwealth.

The act requires the Department of Health to apportion the Commonwealth into dental health districts, administered by a public health dentist within the department, who shall implement dental health policies and programs for the various counties and political subdivisions.

PA **1996 Pa. Laws, Act 141 (HB 2511)** enacts the Volunteer Health Services Act to increase the availability of primary health care services by establishing a procedure through which physicians and other health care practitioners who are retired from active practice may provide professional services as a volunteer in approved clinics serving financially qualified persons and in approved clinics located in medically underserved areas or health professionals shortage areas.

SC **1996 S.C. Acts, Act 390 (H 3915)** authorizes and grants to the Board of Trustees of the Medical University of South Carolina (MUSC) the authority to enter into reasonable agreements to transfer the management and operations of the Medical University Hospital to one or more private operators, subject to certain conditions, including that a private operator must provide indigent care in the same manner as now provided by MUSC. In addition, MUSC must maintain the level of services currently offered to indigent patients at Charleston Memorial Hospital, unless the board decides otherwise. Any discontinuation or transfer of any inpatient clinical service offered at the Medical Center the law requires prior written consent of the Board of Trustees.

Access for anyone or group to use the services of the Medical University Hospital and clinical services must not be limited, restricted, denied, or allowed in a discriminatory manner prohibited by law, nor must access be denied based on lack of participation or membership in a particular health plan or network.

SD **1996 S.D. Sess. Laws, Chap. 295 (HB 1310)** requires that, if an employer has an existing health benefit plan, the carrier must accept for coverage under the health benefit plan new employees and the dependents of new employees, if the new employee had qualifying previous coverage within 30 days from the date the new employee is eligible for coverage. The coverage must be issued without exclusionary riders. The carrier is not required to provide coverage for new employees or dependents who are late enrollees or who have not had qualifying previous coverage within 30 days before applying for definition of eligible dependents.

UT **1996 Utah Laws, Chap. 108 (HB 129)** creates a Medicaid restricted account and states that any general funds appropriated to the Department of Health for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and are not otherwise designated as nonlapsing will lapse into the Medicaid restricted account. The act allows the legislature to appropriate money in the restricted account to fund programs that expand medical assistance coverage and private insurance plans to low-income persons who have not traditionally been serviced by Medicaid.

UT **1996 Utah Laws, Chap. 143 (HB 273)** provides for the establishment of voluntary health purchasing alliances or cooperatives. An alliance is a nonrisk-bearing, nonprofit corporation or trust that makes health insurance available to its members from multiple unaffiliated insurers. The act directs the commissioner of insurance to facilitate the creation and operation of alliances and establishes their powers and duties, including creation of boards, marketing standards, collection of premiums, enrollment procedures and reporting.

UT **1996 Utah Laws, Chap. 276 (HB 404)** provides a tax deduction of 60 percent of the amounts paid by the taxpayer during the taxable year for health care insurance for the taxpayer and his or her spouse and dependents to the extent the amounts paid for health insurance were not deductible under the federal Internal Revenue Code. The act clarifies that a deduction is not allowed for amounts that are reimbursed or funded in whole or in part by government and for a taxpayer who is eligible to participate in a health plan that is funded in whole or in part by the taxpayer's employer. The deduction is allowed for tax years beginning on or after January 1, 1996.

UT **1996 Utah Laws, Chap. 339 (HB 146)** permits an insured person to choose a health care provider or facility when the insurer's provider or facility is not within 30 miles. The act requires the insurer to reimburse the insured's health care provider or facility on the same terms as the insurer reimburses its providers and facilities. The act limits the liability of an insurer for acts or omissions of a provider or facility chosen by an insured. The act also clarifies referral procedures and allows providers and facilities in counties of less than 30,000 people to contract with an insurer on the same terms and conditions as providers or facilities under contract with or employed by the insurer. Finally, the act requires the Health Policy Commission to study issues related to managed health care in rural and frontier Utah and report its findings to the Health and Environment Interim Committee before November 1, 1996.

VT **1996 Vt. Acts, Act 74 (H 534)** restricts further enrollment in the Vermont Health Access "Interim" Program after April 15, 1996, unless rules have been adopted by that date under the Administrative Procedure Act to implement that program and to implement the Vermont Health Access "Pharmacy" Program.

VT **1996 Vt. Acts, Act 180 (S 345)** combines the administration of health care and the quality and cost control oversight into one department. The act changes the administration of health care by terminating the Hospital Data Council and Health Policy Council and creating two new bodies: first, a public oversight commission to review hospital budgets and certificate of need applications and to make recommendations in that regard to the commissioner; and second, a technical review panel to advise the commissioner and the Health Oversight Commission on technical matters related to unified health care budget, resource allocation, utilization review, hospital budgets, quality assurance, the state health plan and other appropriate matters related to the administration of health care. The act also changes the thresholds that trigger certificate of need review. The act also creates more specific quality control and consumer protection requirements for managed care organizations and requires the Department of Banking, Insurance Securities and Health Care Administration to contract with Vermont Program of Quality in Health Care Inc. to implement and maintain a statewide quality assurance system of health care services rendered in Vermont. Under the act, the cost of this system shall be shared by the state and other health insurers and health care provider organizations.

VA **1996 Va. Acts, Chap. 748 (SB 384)** clarifies immunity from liability which is currently provided for health care providers while delivering services without charge. This provision modifies the provisions relating to hospitals, clinics and health professionals to allow a reasonable minimum fee to cover administrative costs for the delivery of medical or other health services as well as dental services and to affirm the immunity of clinics that so charge.

VA **1996 Va. Acts, Chap. 864 (HB 1440)** requires the Department of Medical Assistance Services, in cooperation with the Department of Education, to examine the funding and components of the pilot school/community health centers. The Department may revise these programs. Any revisions must be designed to maximize access to health care for poor children and to improve the funding by making use of every possible, cost-effective means, Medicaid reimbursement or program. Any revisions also must be focused on prevention of large costs for acute or medical care and will include such concerns as: funding sources and means of distribution of the state match; benefits and drawbacks of allowing school divisions to provide services to disabled students as Medicaid providers in cooperation with their primary care physicians; the appropriate credentials of the providers of care in the school health centers; utilization of the Individualized Education Plan (IEP), when signed by a physician, as the plan of care; delivery of medically necessary services; and payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT); and the role of Medallion and Options programs in regard to the school health centers. Any funds necessary to support revisions to the school/community health center projects must be included in the budget estimates for the departments, as appropriate, for the next biennial budget.

WV **1996 W. Va. Acts, Chap. 241 (SB 93)** updates the terms used in the personal income tax laws to bring them into conformity with federal income tax laws. The act states that medical savings accounts are not taxable trusts. Amounts drawn from medical savings accounts which are used for a purpose other than payment of medical expenses are to be added to federal adjusted gross income and a surtax is imposed. Subtracted from federal adjusted gross income are contributions to medical savings accounts not to exceed $2,000, plus interest earned on the account.

WI **1996 Wis. Laws, Act 453 (AB 545)** sets the maximum annual account amount for tax-exempt individual employee medical savings accounts at $2,000 for an individual, $2,000 for his or her spouse and $1,000 for each nonspouse dependent. The act defines a high cost-share health plan as any health insurance policy, certificate, or contract with deductibles, copayments, or other cost-sharing provisions of at least $1,500 if the insured's coverage is single or at least $3,000 if the insured's coverage is family. An employer that establishes a medical savings account on behalf of an employee or a self-employed person is not required to deposit in the account more than $2,000 per year for the employee's spouse or $1,000 per year for each nonspouse dependent of the employee if the employee's coverage is family. Beginning in 1998, the amounts will be increased each year.

The act restricts the medical savings account to specific uses, including to pay expenses for certain medical care, to purchase a long-term care insurance policy or pay long-term care expenses of the employee or self-employed person or any dependents. A person who provides medical care, long-term care, or a long-term care insurance policy that is to be paid with funds in a medical savings account, must bill the employee or self-employed person who is the holder of the account directly, rather than billing the account administrator of the medical savings account.

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CHILD FATALITIES

KY **1996 Ky. Acts, Chap. 347 (HB 94)** authorizes the Department for Health Services to establish a state child fatality response team and every county to establish a local child fatality response team.

NC **1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part III (SB 46, Part III)** continues the Child Fatality Task Force and requires a report to the 1997 General Assembly and to the governor within the first week of the session. The task force also may report to the 1998 regular session and the 1999 General Assembly.

WV **1996 W. Va. Acts, Chap. 84 (HB 4474)** creates the state Child Fatality Review Team under the Office of Medical Examinations, whose function is to investigate the deaths of children under the age of 18. The team will also establish guidelines for hospitals, physicians and other health care providers to utilize in order to identify and report suspicious deaths of children. Government agencies must cooperate with the team by providing any information relating to the death of a child. Actions of the team may not interfere with the duties of the prosecuting attorney or law enforcement.

COORDINATION

AZ **1996 Ariz. Sess. Laws, Chap. 247 (HB 2277)** appropriates a total of $5.4 million from the general fund in both fiscal years 1996-97 and 1997-98 to the Department of Economic Security for continued implementation of the healthy families pilot program ($3 million); the State Board of Education for continued implementation of the family literacy pilot program ($1 million); and the Department of Health Services (DHS) for continued implementation of the healthy start pilot program ($400,000).

The act requires DHS to conduct a study to assess the feasibility of comprehensive program coordination for the healthy start pilot program, including an assessment of the program's goals and the needs of the target populations. DHS is required to report its findings to the Joint Committee on Community Program Evaluation by October 1, 1996. The act requires the joint committee to recommend criteria, by October 1, 1996, for DHS to use in determining which contractors to hire for the healthy start pilot programs, developing a screening method to determine which women are most in need of services and selecting what services are needed.

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the operation and effective period of the perinatal services and perinatal outreach coordination and expansion services and the use of Proposition 99 funds for these services under the Medi-Cal Program.

CT **1996 Conn. Acts, P.A. 96-238 (SB 72)** requires the Department of Public Health (DPH) and the Office of Health Care Access (OHCA), consulting with the Department of Social Services (DSS), to establish a five-year demonstration project to improve access to health care in an area where the viability of traditional acute care hospitals is in question. These agencies must jointly select one hospital willing to terminate its certificate of need (CON) as an acute care hospital and its license as an in-patient hospital. The selected facility must provide an emergency room that must be affiliated with a hospital and uses paramedics, or an ambulatory surgery center.

Under the act, the facility also may provide nursing facility beds if they represent a portion of beds already licensed and occupied as of June 4, 1996, if those nursing beds are relocated from an existing Medicaid-certified nursing facility and the relocation does not result in increased state expenditures and increased nursing beds in the state. The facility also may provide assisted living under a continuing care facility guaranteeing life care for its residents. By January 1, 2001, DPH, DSS and OHCA must report to the Public Health and Human Services committees on the effect on access to health care in the area of the state selected for the project.

DE **Vol. 70 Del. Laws, Sen. Jt. Res. 19** resolves that the Department of Public Instruction and the Department of Health and Social Services submit a plan analyzing existing capacity to educate the state's citizens about cancer and related chronic diseases and their risk factors. The plan should include ways to improve educational efforts; and an estimate of the costs to provide adequate public education, including start-up costs and annual operation and maintenance costs. In addition, the plan should examine existing coordination efforts between the two departments and between the departments and the voluntary and private health providers with an interest in cancer education and explain how the departments intend to coordinate future efforts, including school-based health centers, in developing expanded comprehensive health education. The proposal also should evaluate how existing school health curricula are being implemented at the local and district levels and make recommendations on a public awareness campaign about the risks of tobacco use targeted at youth and how to incorporate skill-building activities for healthier alternative behaviors in comprehensive school health education programs at all levels. The plan should also address how to educate the general population on the prevention of chronic diseases in general and cancer specifically. The plan must be submitted to the General Assembly on or before January 1, 1997.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** directs the Agency for Health Care Administration (AHCA) to work with the Department of Insurance, the Department of Health and Rehabilitative Services, the Department of Education, the Department of Elderly Affairs and provider groups to study the feasibility of non-risk-bearing alternative service networks for Medicaid recipients. (See the chapter on Access and Reform for more details.)

FL **1996 Fla. Laws, Chap. 403 (HB 555)** establishes the Public Health and Health Care Administration Act of 1996. The act creates a new agency, the Department of Health (DOH) to serve as the single state agency responsible for all health matters for which the state has authority. The act transfers the Agency for Health Care Administration, the Agency for Public Health Services and the Division of Medical Quality Assurances to DOH. The act transfers the duties of the Department of Health and Rehabilitative Services, Children's Medical Services Program Office and the Alcohol, Drug Abuse and Mental Health Program Office to the Agency for Public Health Services. The act transfers the duties of the Health Care Board to the Agency for Health Care Administration, effective October 1, 1997. The act authorizes the DOH to establish uniform application forms and certificates of licensure for use by the boards within the department. Each board with five or more members is required to have at least two consumer members who are not and have never been, members of the profession regulated by the board. Boards with fewer than five members must have at least one consumer member outside of the profession.

Finally, the act creates a task force to make recommendations on the structure and organization of publicly funded health-related programs and agencies; the organizational placement of health facility and health care practitioner regulation that will ensure the highest quality of health care; the role and mission of local and state agencies with public health care functions; methods for coordinating health services delivery with health care financing, policy, purchasing and regulatory requirements; and the advantages and disadvantages of centralizing health care administration and accountability. A report is due to the governor and Legislature by December 31, 1996.

FL **1996 Fla. Laws, Chap. 420 (HB 2717)** authorizes the Agency for Health Care Administration to apply managed care strategies to children's therapeutic services and requires that the agency coordinate with the Department of Juvenile Justice and the Alcohol, Drug Abuse and Mental Health Program Office and Children and Families Program Office of the Department of Health and Rehabilitative Services to develop the appropriate clinical protocols and identify the services to be included for preauthorization and utilization management.

FL **1996 Fla. Laws, Chap. 509 (HB 2005)** clarifies that the Palm Beach County Health Care District's authority includes the ability to plan, set policy and fund from its revenue sources the establishment and implementation of cooperative agreements with other government authorities and public and private entities within and outside of Palm Beach County which promote the efficiencies of local and regional trauma agencies, rural health networks and cooperative health care delivery systems, provided that any agreements with entities outside of Palm Beach County ensure that the costs associated with trauma services are the responsibility of that entity. The district also has the authority to reorganize any of the hospitals it owns in accordance with state law.

HI **1996 Hawaii Sess. Laws, Act 125 (HB 3498)** assigns the responsibility for the coordination of mental health services for children and adolescents required by the *Felix vs. Cayetano* settlements agreement and any future legal actions to the Department of Health.

HI **1996 Hawaii Sess. Laws, Act 287 (HB 2800)** makes appropriations to the Department of Education, the Department of Human Services and the Department of Health, provided that the departments work together to develop working agreements regarding services provided to children through school-based health centers. These agencies are required to create an interdepartmental program for the development of pilot projects to demonstrate mental health, education and protective services to children and adolescents who are clients of more than one agency.

ID **1996 Idaho Sess. Laws, Chap. 26 (HB 535)** amends, adds to and repeals existing law to bring advanced life support and emergency medical services into a consistent program administered by the Board of Health and Welfare with medical oversight by the Board of Medicine.

ID **1996 Idaho Sess. Laws, Chap. 147 (SB 1439)** requires the director of the Department of Health and Welfare to establish a statewide poison control center that provides 24-hour emergency telephone service determining whether treatment can be accomplished at the scene of the incident or transport to an emergency room or other facility is required and carrying out telephone follow-up to families and other individuals to assure that adequate care is provided. The act also provides 24-hour emergency telephone referral of poison victims, information to health professionals involved in management of poisoning and overdose victims and community poison prevention education programs. The director must establish a system for consulting with other state agency programs concerned with poisons and poisonings to develop the most coordinated and consistent response possible.

IL **1996 Ill. Laws, P.A. 89-507 (HB 2632)** directs that the Departments of Alcoholism and Substance Abuse; Mental Health and Developmental Disabilities; and Rehabilitative Services are to become the Department of Human Services (DHS) on July 1, 1997. The new agency will also succeed to all powers of the Department of Children and Family Services to coordinate day-care resources and to provide direct child welfare services; supportive services and living maintenance to pregnant, unmarried minors; and shelter and independent living services for homeless youth. DHS will also have responsibility for these health issues: infant mortality reduction; diabetes prevention; addicted pregnant women; and hemophilia treatment. It will succeed to all powers of the Department of Public Health as to the federal Women, Infants and Children (WIC) Program and to some other powers of the Departments of Public Aid, Public Health and Children and Family Services. (Note: HB 22--P.A. 89-506 creates a Task Force on Human Services Consolidation appointed by the governor and legislative leaders to gather facts and make recommendations on further human services consolidations and report in early 1997, 1998 and 1999.)

IA **1996 Iowa Acts, Chap. 1084 (SF 2307)** relates to the Comprehensive Family Support Program for individuals with a disability and their families and provides for coordination of programs available to individuals with disabilities with other programs administered by the Department of Human Services. The act requires statewide implementation of the support program in a manner that enables individual choice of services and other provisions to individualize the manner in which the program is implemented. The act also requires that the application process be coordinated with the eligibility processes used by other programs, requires services and support to be provided in a timely manner with provision for emergency services and requires the department to assist eligible families in locating services and in identifying the components of service plans. The act includes provisions for a children-at-home component of the program. Under this component, the department assists a family member of an eligible family in identifying services and support needed. The act directs the department to develop a contract for direct payment utilizing vouchers for the services and other support provided to the family.

IA **1996 Iowa Acts, Chap. 1156 (SF 2294)** enables a county or multicounty consortium of agencies providing health, counseling, economic assistance, education, law enforcement, or therapeutic services to establish a multidisciplinary team for the more effective planning and delivery of services to an individual or family under the following conditions and may disclose confidential information to each other as long as specified confidentiality standards are met.

IA **1996 Iowa Acts, Chap. 1183 (HF 2427)** institutes a single entry point process for services relating to mental health, mental retardation, developmental disabilities and other services that are paid for in whole or in part by counties or the state. The act also amends county participation in funding for services to people with disabilities provisions to specify that the state shall pay for 100 percent of the nonfederal share of the services paid for under any prepaid mental health services plan for medical assistance implemented by the department as authorized by law.

KY **1996 Ky. Acts, Chap. 197 (HJR 80)** directs a study of the health and human service delivery system in Kentucky to be conducted by the Cabinet for Human Resources with a report and recommendation in the form of legislative proposals on improvements in the efficiency and economy of the service delivery system to be submitted to the governor and the Legislative Research Commission by October 1, 1997.

LA **1996 La. Acts, Sen. Concur. Res. 22** requests the Commission on Perinatal Care and Prevention of Infant Mortality to invite the secretary of the Department of Social Services or his designee and the superintendent of the state Department of Education or his designee, to attend the meetings of the commission.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following.

The act creates an integrated state-level health delivery system for those in need of state services by combining most of the funding and functions of the Department of Mental Health, the Department of Public Health and Medicaid into a single organization.

From the funds appropriated for the indigent medical care program, the department must establish a program that provides for the basic health care needs of indigent people and eligibility for the program is limited to the following: people currently receiving cash grants under either the family independence program or state disability assistance programs who are not eligible for any other public or private health care coverage; and any other resident of the state who currently meets the income and asset requirements for the state disability assistance program and is not eligible for any other public or private health care coverage. The program must provide for the following minimum level of services for enrolled individuals: physician services provided in private, clinic, or outpatient office settings; diagnostic laboratory and x-ray services; and pharmaceutical services.

The act also authorizes the Department of Community Health, in cooperation with the Family Independence Agency to establish a pilot project for those who work their way off welfare to purchase Medicaid coverage at a rate determined by the department. The department may receive and expend premiums for the buy-in of Medicaid coverage in addition to the amounts appropriated in this act.

MI **Exec. Reorg. Ord. No. 1996-1** reorganizes health-related administrative functions in state government and transfers authority, powers, duties, functions and responsibilities related to the reorganization. The executive order renames the Department of Mental Health as the Department of Community Health and renames the Department of Public Health as the Community Public Health Agency. The order declares that the future in state-funded and administered health and behavioral services lies in integrating administrative systems and pooling state purchasing power for more efficient use of resources; the administration of health-related programs is fragmented throughout state government in at least eight state departments, causing duplication of services and waste of resources; these health services can and should be better coordinated for the basic protection of the health of Michigan citizens; and the state's role will increasingly focus on quality assurance and purchasing quality outcomes rather than on regulation.

The executive order transfers the Medicaid program and state Medical Program from the Department of Social Services to the Department of Community Health. It transfers numerous functions from the Department of Public Health to the Department of Community Health, including the Bureau of Child and Family Services, the Children's Special Health Care Advisory Committee, the Center for Health Promotion and Chronic Disease Prevention, the Center for Substance Abuse

Services, the Division of Managed Care, the Bureau of Infectious Disease Control, the Public Health Institute and the Risk Reduction and AIDS Policy Commission, among others.

The executive order also transfers from the Department of Public Health to the Department of Commerce the duties of the Division of Health Facility Licensing and Certification; the Division of Emergency Medical Services; the duties of licensing substance abuse programs and certification of substance abuse workers; and mental health code licensing, monitoring and accreditation duties.

The order transfers the WIC program from the Department of Public Health to the Department of Social Services. It also transfers alcohol prevention education functions from the Liquor Control Commission to the Department of Community Health.

MS **1996 Miss. Laws, Chap. 476 (HB 87)** reestablishes the Children's Advisory Council to pilot the development of a coordinated system for services and care for children who are emotionally disturbed or mentally ill. The act revises the functions and the scope of the coordinated interagency system of children services pilot program and the composition and responsibilities of the council and the local coordinating care entity. The act provides that after the first year of the program, the Children's Advisory Council will add additional coordinating care entities so that all children in the state served by this act will be covered by the third year. The act provides for the contribution of funds into a pool of funds by participating agencies, including the Department of Human Services, the Department of Mental Health and the Department of Education. By the first quarter of each fiscal year, each of these agencies must pay into the special fund out of its annual appropriation, a sum to be determined by the governing board of each agency or other duly authorized state level oversight authority. The act provides that in lieu of contributing funds, the Department of Health must contribute to the pilot in-kind health/medical services.

NE **1996 Neb. Laws, L.B. 1044** authorizes the merger of the Department of Aging, the Department of Health, the Department of Public Institutions, the Department of Social Services and the Office of Juvenile Services of the Department of Correctional Services. The merger will combine the functions and responsibilities of these entities into three agencies. The agencies will be: the Department of Health and Human Services, which will carry out all service-related functions; the Department of Health and Human Services Regulation and Licensure, which will administer the licensing, rule-making and evaluation functions; and the Department of Health and Human Services Finances and Support, which will provide financial and administrative support to the three agencies. The act creates a Partnership Council, consisting of seven to 15 members, appointed by the governor and approved by the Legislature, to advise the agency directors and policy secretary.

The Legislature's intent is that the merger will reduce the size of state personnel and state expenditures, focus on local control and consider privatization of services. The act requires current agency directors to submit a report to the governor and Legislature by December 1, 1996, which will include a transition plan for implementation of the redesign of the five agencies. The report will also include draft legislation necessary for full implementation of proposed program and policy changes.

NC **1996 N.C. Sess. Laws, Chap. 690 (SB 709)** gives counties with a population in excess of 425,000 the authority to establish a different system of managing human services in the county. Under current law, human services are provided in counties through three separate boards: social services, health and mental health. Each county appoints its own director, who in turn is responsible for appointing appropriate personnel. Each board presents a budget for its service to the board of commissioners. This act eliminates the three independent boards and their directors for large counties and gives the county manager the authority to appoint a human services director. The act establishes a consolidated human services board that is a policymaking body and not a management body. The act establishes a consolidated human services agency that has the same powers as the three boards that are eliminated, except that the new agency cannot appoint its director or submit its own budget request directly to the county commissioners. The act removes personnel of the consolidated agency from the State Personnel Act and requires the secretaries of the Department of Human Resources and the Department of Environment, Health and Natural Resources to adopt rules to allow dedicated funding streams to flow to a consolidated agency and board. The counties that adopt the consolidated agency must report to specified legislative committees by January 1, 1998 and annually thereafter, until January 1, 2001.

TN **1996 Tenn. Pub. Acts, Chap. 954 (H 1684)** allows the state Department of Education to establish pilot programs of community-based early childhood education and pre-kindergarten programs to address the health, educational and social service needs of children ages three and four who live below the poverty line and who are not otherwise eligible for similar programs or who do not have access to such programs and/or who are at risk of educational disadvantage and failure due to circumstances of abuse, neglect, disability, or who are at risk of state custody due to a family dysfunction. A reasonable, sliding fee scale based upon the family's income may be established for a student enrolled in any such program.

All early childhood education and pre-kindergarten programs established under this act must be developed through a system of competitive grants and technical assistance using a collaborative effort of the built upon resources and services within the community. Programs should strive to assist families by providing full-day, year-round services. Programs should include a daily component of developmentally appropriate educational activities and, where possible, child care for the children of parents who need extended day services. The act requires the Department of Education to submit a report of findings and recommendations to the governor, state board of education and General Assembly at least once each year.

TN **1996 Tenn. Pub. Acts, Chap. 1079 (S 3176)** creates the Tennessee Department of Children's Services, with a primary focus on providing services to children who are determined to be delinquent, dependent and neglected and those at risk of entering state custody. The act also emphasizes family preservation and requires the department to strive to ensure that health care needs, both preventative and practical, are met; and to pursue to provide appropriate and effective behavioral and mental health treatment.

UT **1996 Utah Laws, Chap. 229 (HB 135)** encourages collaboration between school districts, local health departments and private medical providers to determine needs and risks to students' health and develop and implement plans to minimize risks and meet needs. School districts are encouraged to provide one registered nurse for every 5,000 students, or, in districts with fewer than 5,000 students, at a level of service recommended by the Department of Health. The act provides for a School Nursing Services Incentive Program to encourage collaborative planning between school districts and local health departments. Incentive money is available by application and are distributed by formula.

VT **1996 Vt. Acts, Act 180 (S 345)** combines the administration of health care and the quality and cost control oversight into one department. The act changes the administration of health care by terminating the Hospital Data Council and Health Policy Council and creating two new bodies: first, a public oversight commission to review hospital budgets and certificate of need applications and to make recommendations in that regard to the commissioner; and second, a technical review panel to advise the commissioner and the Health Oversight Commission on technical matters related to unified health care budget, resource allocation, utilization review, hospital budgets, quality assurance, the state health plan and other appropriate matters related to the administration of health care. The act also changes the thresholds that trigger certificate of need review.

DATA AND QUALITY

CT **1996 Conn. Acts, P.A. 96-160 (SB 28)** eliminates the requirement that the Department of Public Health (DPH) reserve two percent of the Maternal and Child Health Protection Program's funds for program evaluation. The act requires the DPH to evaluate the program using outcome measures developed in consultation with the Office of Policy and Management. The Maternal and Child Health Protection Program provides outpatient maternal health services and labor and delivery services to needy women and health services to children under age six. DPH must contract with local health service providers to serve families with an adjusted gross income at or under 185 percent of federal poverty guidelines who do not have private insurance that covers these services.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** requires a health care quality improvement system for all providers with Medicaid contracts. AHCA must publish and make available to MediPass and fee-for-service patients, a toll-free telephone number to handle consumer complaints and maintain a statewide database of the complaints. Possibly using the Children's Medical Services network as a model.

HI **1996 Hawaii Sess. Laws, H. Res. 152** urges the governor to reaffirm the trust responsibility of all executive departments to improve the health status of Hawaiians by requesting the Departments of Human Services and Health to redirect resources toward primary prevention activities, requesting the Department of Health to reinstitute health data collecting procedures towards a more complete statistical picture of the health status of Hawaii's minorities and requesting the Department of Health to finalize and submit for review an action plan and timetable for implementation of comprehensive health care initiatives for Hawaiians. The governor is requested to submit findings and recommendations to the legislature no later than 20 days before the convening of the 1997 regular session.

IL **1996 Ill. Laws, P.A. 89-554 (HB 2587)** amends the Illinois Health Finance Reform Act to require the Illinois Health Care Cost Containment Council to establish a system for the collection of outpatient surgical data. The act allows the council to gather data by survey and requires a field test of the ambulatory surgery treatment center data collection system beginning no later than July 1, 1997.

IA **1996 Iowa Acts, Chap. 1108 (SF 2218)** relates to the Community Health Management Information System (CHMIS), which is administered by a nonprofit organization and under the regulatory authority of the Insurance Division of the Department of Commerce. This system provides for the collection and submission of health care billing information and other data. The act extends by one year, from July 1, 1996, to July 1, 1997, the date by which Phase I of the system is to be implemented. "Phase I" means the collection and submission of certain identified data. In addition, the CHMIS Governing Board is to review the policies and procedures for ensuring the confidentiality of information in the system and the penalties applicable to unauthorized release of the information.

ME **1996 Maine Laws, Chap. 653 (LD 1788)** creates the Maine Health Data Organization (MHDO) to continue the data collection efforts of the Maine Health Care Finance Commission, which expired on June 10, 1996. The act provides for the establishment and duties of the MHDO governing board, with board members representing consumers, employers, payers and providers.

The act directs the board to establish uniform reporting systems. The board must develop and implement data collection policies and procedures for the collection, procession, storage and analysis of clinical, financial and restructuring data. The act directs the board to integrate data systems, standardize concepts and coordinate the development of a linked public and private sector information system. The board must emphasize data that are relevant and not duplicative of existing data and minimize the burden on those providing data. In addition, the board is directed to preserve the accuracy of collected data while ensuring that the data are available in the public domain.

The act retains current requirements for information to be submitted by facilities, providers and payers. Each health care facility must file with the organization scope of service information and completed uniform hospital discharge data set, or comparable information, for each patient discharge from the facility, for each major ambulatory service listed in rules adopted by the organization and for each hospital outpatient service. Each health care facility must file with the organization financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges and units of services. The act provides for confidentiality, use of data for research purposes and access to aggregate data.

To finance the Maine Health Data Organization during the transition, the act allows all hospitals except state hospitals to be assessed not more than .07 percent of their gross patient revenues, not to exceed $775,000 for all hospitals. Each hospital must pay the assessment quarterly. The act requires the board to submit legislation to establish fees and assessments for permanent funding.

In order to conduct quality improvement research, the board is authorized to designate a quality improvement foundation if the board finds that the foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and has protocols to safeguard confidential and privileged information.

MA **1996 Mass. Acts, Chap. 307 (HB 5662)** requires the Board of Registration in Medicine to create a clinical quality improvement unit to identify cases that appear to involve substandard care and develop procedures for investigation and possible disciplinary action. The act requires the board to create a voluntary remediation program designed to improve physicians' clinical and communication skills, to be offered as an alternative to disciplinary action.

The act allows the board to create individual provider profiles and disseminate them to the public. The act specifies what information should be included in the profiles. The act requires that providers be given the chance to review their profile before publication and make corrections and additions.

For any reports that compare individual health care providers, the act requires that those providers be meaningfully involved in the development of all aspects of the profile methodology. The limitations of the data sources and analytic methodologies used to develop provider profiles must be clearly identified. Comparisons among provider profiles must adjust for patient case-mix and other relevant risk factors. The act requires safeguards to protect against the unauthorized use or disclosure of provider profiles and the dissemination of faulty data. The quality and accuracy of provider profiles, data sources and methodologies must be evaluated regularly. The act requires providers to be reimbursed for the reasonable costs required for providing the necessary data. Finally, the act allows the board to disseminate physician profiles by electronic media, including the World Wide Web or on CD-ROM after May 1, 1997. The board must conduct a study on the impact of publication of physician profiles by electronic media.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following: the department may require medical services recipients to receive psychiatric services through a managed care system and must continue to implement managed care and require medical services recipients residing in counties offering managed care options to choose the particular managed care plan in which they wish to be enrolled. Those not expressing a preference shall be assigned to a managed care provider. The department must obtain from those HMOs and clinic plans with which the department contracts patient-based utilization data, including immunizations, early and periodic screenings, diagnoses, and treatments, substance abuse services, and maternal and infant support services referrals.

The act enables the department to increase enrollment of Medicaid-eligible persons in capitated health plans during fiscal year 1996-97. Mandatory enrollment may occur for the elderly, the disabled, the medically needy, individuals with mental illness, individuals who have a developmental disability, children with serious emotional disturbance, and recipients of children's special health care services if both of the following conditions are met: continuity of care is assured by allowing enrollees to continue receiving currently required medically necessary services from their primary providers for a period not to exceed a year; and a contract for an independent evaluation is in place to measure cost, access, quality and patient satisfaction. The department must provide a report on the progress of the Medicaid managed mental health care program to the legislature by September 30, 1997.

The department must establish uniform quality and reporting standards for all capitated health plans with which it contracts. At least 30 days prior to the implementation of such standards, the department shall report on the standards developed to the House and Senate appropriations subcommittees on community health and fiscal agencies. The act also specifies many other quality control requirements for Medicaid capitated health plans. (See Medicaid for more information)

MN **1996 Minn. Laws, Chap. 440 (SF 2410)** specifies that provider organizations and individual health care providers are to use the first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration (HCFA) as their unique provider number. Provider organizations required to obtain a national provider identifier from HCFA include hospitals, nursing homes and hospices, subacute care facilities, individual providers organized as a clinic or group practice, independent laboratory, ambulance services and special transportation services. Individual providers required to have a national provider identifier include physicians, dentists, chiropractors, podiatrists, physician assistants, advanced practice nurses, doctors of optometry, individual providers who may bill Medicare for medical and other health services and individual providers who are providers for state and federal health care programs administered by the commissioner of human services. The act specifies that the payer identification number assigned for the federal HCFA's PAYREID system will be used as the unique identification number for group purchasers. The act also requires group purchasers to obtain a payer ID number from HCFA.

The act establishes procedures for disclosing certain nonpublic data to related group purchasers. The act authorizes the commissioner to publish, or release to the public by other means, the named identity of a group purchaser as part of an analysis of information collected from the birth registration. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data, the commissioner must include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. The provision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

NY **1996 N.Y. Laws, Chap. 279 (S 7884)** enacts the Pesticide Registry Act in order to assess the effect of pesticides on human health through public health research and improved recordkeeping of pesticide use. The act establishes a computerized pesticide database to be made available to the public and to health researchers.

TN **1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)** requires the TennCare Bureau to file a report at least annually setting forth data and statistics relative to health care provided to women. The act directs the TennCare Bureau and the Tennessee Department of Health to develop data measures to assess the effectiveness of presumptive eligibility, the distribution of providers for each managed care organization for TennCare enrollees within each health region and the incidences of early prenatal care for TennCare recipients. The managed care organizations are required to report regularly to the TennCare Bureau using the data measures developed.

UT **1996 Utah Laws, Chap. 201 (SB 171)** amends the duties of the Health Data Committee and the Department of Health for the collection of health care data. Confidentiality provisions are amended and the Health Data Committee is authorized to publish reports comparing and identifying health care providers. Data must be reviewed by an independent analyst. The supplier of the data must be given a reasonable amount of time before publication to review the committee's interpretation of the data and prepare a response. The act also repeals limitations on the use of health data and certain confidentiality requirements.

VT **1996 Vt. Acts, Act 180 (S 345)** combines the administration of health care and the quality and cost control oversight into one department. The act changes the administration of health care by terminating the Hospital Data Council and Health Policy Council and creating two new bodies: first, a public oversight commission to review hospital budgets and certificate of need applications and to make recommendations in that regard to the commissioner; and second, a technical review panel to advise the commissioner and the Health Oversight Commission on technical matters related to unified health care budget, resource allocation, utilization review, hospital budgets, quality assurance, the state health plan and other appropriate matters related to the administration of health care. The act also changes the thresholds that trigger certificate of need review. The act also creates more specific quality control and consumer protection requirements for managed care organizations and requires the Department of Banking, Insurance Securities and Health Care Administration to contract with Vermont Program of Quality in Health Care Inc. to implement and maintain a statewide quality assurance system of health care services rendered in Vermont. Under the act, the cost of this system shall be shared by the state and other health insurers and health care provider organizations.

EMERGENCY MEDICAL SERVICES

(WITH EMPHASIS ON ACCESS AND CHILDREN'S ISSUES)

AL	**1996 Ala. Acts, Sen. Jt. Res. 101** designates the week of May 19-25, 1996, as Emergency Medical Services Week and acknowledges emergency medical services specialists for many activities including that they save hundreds of lives not only with their medical assistance, but also with their prevention message: they remind citizens about the dangers of drinking and driving, about the importance of wearing safety belts, about using safety belts for our children, about the necessity of motorcyclists wearing helmets and about becoming alert pedestrians.
AZ	**1996 Ariz. Sess. Laws, Chap. 132 (SB 1286)** requires health plans to provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required by the Emergency Medical Treatment and Active Labor Act without prior authorization by the plan, subject to applicable copayments, coinsurance and deductibles. A provider may not deny, limit or otherwise restrict a patient's access to medically necessary emergency services based upon the patient's enrollment in a health plan. The act allows a health plan to require, as a condition of coverage, prior authorization for health care services arising after the initial screening and stabilizing treatment. In such cases, the health plan must provide enrollees 24-hour access by telephone or facsimile.
CA	**1996 Cal. Stats., Chap. 197 (AB 3483)** establishes the Emergency Medical Services for Children Program within the Emergency Medical Services Authority and states that no more than $120,000 per fiscal year be expended for the program.
CA	**1996 Cal. Stats., Chap. 199 (AB 3487)** extends the several programs funded by Cigarette and Tobacco Products Surtax Fund money including, emergency treatment of out of county indigent patients. The act also revises reporting and maintenance of effort requirements under the California Health Care for the Indigent
CA	**1996 Cal. Stats., Chap. 1012 (AB 2577)** allows San Luis Obispo County to close its county hospital emergency room and contract with non-county hospitals for emergency room services without risk of losing state funding for indigent health care.
DE	**Vol. 70 Del. Laws, Chap. 453 (HB 433)** establishes a voluntary and inclusive statewide trauma care system and provides for the creation of a statewide trauma plan addressing pre-hospital care, prevention, hospital care, rehabilitative care, continuing education and trauma system evaluation. The act also permits representation of the Trauma Systems Committee on the Delaware Emergency Medical Services Advisory Council to safeguard against fragmentation of the Delaware EMS System. The act also protects the confidentiality of all quality management proceedings related to the trauma care system.
FL	**1996 Fla. Laws, Chap. 223 (SB 910)** prohibits certain misrepresentations by HMOs on the availability of providers and specifies requirements for HMOs in providing emergency services and

care. The act specifies an emergency medical condition with respect to a pregnant woman to mean there is inadequate time to effect safe transfer to another hospital before delivery, a transfer may pose a threat to the health and safety of the patient or fetus, or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

FL **1996 Fla. Laws, Chap. 509 (HB 2005)** clarifies that the Palm Beach County Health Care District's authority includes the ability to plan, set policy and fund from its revenue sources the establishment and implementation of cooperative agreements with other government authorities and public and private entities within and outside of Palm Beach County which promote the efficiencies of local and regional trauma agencies, rural health networks and cooperative health care delivery systems, provided that any agreements with entities outside of Palm Beach County ensure that the costs associated with trauma services are the responsibility of that entity. The district also has the authority to reorganize any of the hospitals it owns in accordance with state law.

GA **1996 Ga. Laws, p. 751 (H 1338)** enacts the Patient Protection Act, with provisions for the certification and regulation of managed health care plans by the commissioner of insurance. Among other provisions, the act uses the prudent layperson test to define emergency care services as services that are provided for a condition of recent onset and sufficient severity, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The act specifies that prior authorization is not required for the reimbursement of these services. (See "Insurance and Managed Care" and "Providers" for more information.)

GU **1996 Guam Laws, P.L. 23-77** designates the Guam Fire Department as the central agency for the overall operation of the island's 911 emergency medical services system; requires the commission to adopt rules and regulations for the operation and implementation of the EMS System, the administration of the commission and the standards for certification of emergency medical services.

ID **1996 Idaho Sess. Laws, Chap. 26 (HB 535)** amends, adds to and repeals existing law to bring advanced life support and emergency medical services into a consistent program administered by the Board of Health and Welfare with medical oversight by the Board of Medicine.

ID **1996 Idaho Sess. Laws, Chap. 147 (SB 1439)** requires the director of the Department of Health and Welfare to establish a statewide poison control center that provides 24-hour emergency telephone service determining whether treatment can be accomplished at the scene of the incident or transport to an emergency room or other facility is required and carrying out telephone follow-up to families and other individuals to assure that adequate care is provided. The act also provides 24-hour emergency telephone referral of poison victims, information to health professionals involved in management of poisoning and overdose victims and community poison prevention education programs. The director must establish a system for consulting with other state agency programs concerned with poisons and poisonings to develop the most coordinated and consistent response possible.

IL **1996 Ill. Laws, P.A. 89-516 (HB 3309)** allows the Illinois Department of Public Health (IDPH) to issue an annual Freestanding Emergency Center Demonstration License to a facility meeting several criteria. The center must have at least one board-certified emergency physician and a crew of paramedics present and must offer comprehensive emergency treatment 24 hours a day. The demonstration program will last until September 1998 but may be extended two more years. People convicted of firearm or drug crimes must pay a $100 "fee" to go to the Trauma Center Fund in the state treasury for distribution to hospitals designated as trauma centers.

IL **1996 Ill. Laws, P.A. 89-646 (SB 1513)** amends the Public Aid Code to provide that a local governmental unit in any county may elect to provide, at a minimum, under the General Assistance Program, financial aid for emergency medical treatment, care and supplies only, deleting the term "necessary treatment, care and supplies required because of illness or disability." The act requires that the General Assistance rules of the local governmental unit must specify the emergency treatment for which financial aid is provided and must include medical treatment, care and supplies

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necessitated by a condition that is life-threatening, will result in significant and permanent physical impairment, or requires immediate attention to relieve significant present physical pain and suffering. The act provides that a township, township supervisor, or township employee is not liable for injury caused by a decision to grant or deny aid under the Article on General Assistance.

IL **1996 Ill. Laws, P.A. 89-667 (SB 1327)** allows the Illinois Department of Public Health to investigate a hospital in an Emergency Medical Services (EMS) system that goes on "bypass status" to determine whether that action was reasonable and to fine a hospital for unreasonably going on this status. The act also requires each EMS system and its trauma center medical directors' committee to send the department, within 90 days after enactment, an internal disaster plan describing contingency plans to transfer patients to other facilities in a catastrophe.

IA **1996 Iowa Acts, Chap. 1061 (HF 523)** requires the director of the Iowa Law Enforcement Academy to adopt rules establishing minimum standards for the training of telecommunicators, which are people who receive requests for, or dispatch requests to, emergency response agencies that include law enforcement, fire, rescue, emergency medical services and other similar agencies.

MD **1996 Md. Laws, Chap. 503 (HB 859)** requires HMOs to reimburse hospital emergency facilities and providers (minus the applicable copayment) for medically necessary services provided to an HMO enrollee, if the HMO authorized, directed, referred, or allowed the use of the emergency facility and the services are related to the condition for which the member was allowed to use the emergency facility. The act stipulates that a provider is not required to obtain prior authorization or approval for payment from an HMO in order to obtain reimbursement. The act authorizes the hospital, provider, or insurer that has reimbursed a provider to collect or attempt to collect payment from an enrollee for a medical condition that is determined not to be an emergency.

The act requires HMOs to provide to members a statement of the potential responsibility of the member to pay for services the member seeks to obtain from a provider, including a physician or hospital, that does not have a written contract with the HMO. In addition, HMOs must provide members with a description of procedures to be followed for emergency services, including the appropriate use of hospital emergency facilities; the appropriate use, location and hours of operation of any urgent care facilities operated by the HMO; and the potential responsibility of subscribers and enrollees for payment for emergency services or nonemergency services rendered in a hospital emergency facility.

NH **1996 N.H. Laws, Chap. 274 (SB 578)** allows the state police, county sheriffs, the office of emergency management, or the bureau of emergency communications to intercept, record, or disclose emergency telecommunications when necessary for the rendition of service or the protection of life or property.

NJ **1996 N.J. Laws, Chap. 136 (AB 1554)** expands the number of people who may provide cardiac defibrillation services to traffic accident victims or victims of other emergency situations by allowing police and fire personnel to be able to use automated external defibrillators.

NM **1996 N.M. Laws, Sen. Jt. Mem. 32** requests that the Human Services Department include expanded emergency medical services for reimbursement under Medicaid or its successor program.

NM **1996 N.M. Laws, Sen. Jt. Res. 31** resolves that the Department of Health study the feasibility of expanded emergency medical services in rural, medically underserved communities throughout the state as one major asset to be included in any managed care plans for the area. The department is requested to report its findings to the interim legislative health and human services committee at its October 1996 meeting.

OH **1996 Ohio Laws, H. 405** requires the State Board of Emergency Medical Services to certify as a "first responder" an applicant who is a volunteer for a nonprofit emergency medical service organization or nonprofit fire department, unless this requirement is waived by the board, holds a certificate of completion of an accredited training program, passes a board-administered examination for first responders and meets other specified requirements. The act establishes the scope of practice of a first responder as one who is authorized to provide limited emergency medical services to patients until the arrival of an emergency medical technician and who must receive, unless communications fail, authorization before performing other services specified in the board's rules. The act extends civil immunity to first responders similar to the immunity of other emergency medical technicians.

PA **1996 Pa. Laws, Act 112 (HB 1415)** requires insurers to provide reimbursement for "medically necessary" treatment received in an emergency room. The act defines "medical emergency" as a medical condition with acute symptoms of severity or severe pain for which care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and the absence of immediate medical attention could result in placing health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any body part, or other serious medical consequences. The act requires a hospital emergency room to provide an insurer with any claim for reimbursement of services information on the presenting symptoms of the insured as well as the services provided. An insurer must consider both the presenting symptoms and the services provided in processing a claim or reimbursement of emergency services.

WV **1996 W. Va. Acts, Chap. 144 (SB 465)** requires that health insurance policies include coverage for emergency services, with the same deductibles, coinsurance and other limitations as apply to other covered services. Preauthorization or precertification may not be required.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** provides that when a HMO enrollee receives covered emergency health care services from a noncontracting provider, the HMO is responsible for payment of the provider's normal charges for those health care services, exclusive of any applicable deductibles or copayments. In addition, the act expresses legislative intent that ambulance services in the state are performed by various volunteer emergency service squads, county operations and small businesses that may lack the sophistication and expertise required to negotiate a contract with an HMO for the provision of ambulance services and that the best interests of the state require the continued development and preservation of an emergency medical system to serve all the citizens of the state, including those who do not receive health care services through an HMO. The act directs the commissioner of insurance to promulgate legislative rules to regulate contracting for emergency medical services, including reimbursement for nonemergency transportation by non-participating providers and the appropriate use of 911 or community dispatching. The promulgated rules will be considered by the legislature in the 1997 regular session.

The act amends the definition of health care services to include chiropractic services and pediatric services. The definition of primary care physician is amended to allow a certified nurse-midwife to be chosen in lieu of a subscriber's primary care physician during the subscriber's pregnancy and for a period extending through the end of the month in which the 60-day period following termination of pregnancy.

The act requires that certain additional information be added to the current requirements for the issuance of a certificate of authority whenever there is a change in membership of the governing body of an HMO or in the officers or those holding five percent or more of the common stock of the organization. The act further provides that all certificates of authority expire on May 31 of each year and that a fee shall be charged for each renewal of a certificate of authority.

ENVIRONMENTAL HAZARDS

DC **1996 D.C. Stats., Act 11-438 (Bill No. 11-640)** establishes a program to reduce, eliminate and abate lead-based paint hazards in the District of Columbia. The act requires the mayor to establish a program to include development of standards and procedures for conducting lead-based paint activities; community outreach and education; and other functions to implement this act to meet federal requirements.

IA **1996 Iowa Acts, Chap. 1161 (SF 2301)** directs the Iowa Department of Public Health to establish a program for the training and certification of lead inspectors and lead abaters who provide inspections and abatement for monetary compensation. The department is also directed to establish a program for the training, on a voluntary basis, of painting, demolition and remodeling contractors and those who provide mitigation control services for monetary compensation. The act authorizes the department to develop voluntary guidelines to be used to develop and administer local programs to address the health and environmental needs of children who are lead-poisoned. The act provides that cities or counties may utilize the guidelines developed for local programs or may request that the state develop and administer a local program. The act is effective contingent upon the department obtaining certification from the U.S. Environmental Protection Agency as an accredited program, however, the act permits the department to establish a voluntary program in the interim.

KY **1996 Ky. Acts, Chap. 168 (SB 182)** establishes certification and other requirements for lead-hazard detection or abatement services.

ME **1996 Maine Laws, Chap. 572 (LD 1445)** lowers the cap on lead-poisoning liability from $750,000 to $600,000 and changes the repeal date for the cap from April 15, 1996, to October 1, 1999. The act also creates a task force to study issues related to the availability of insurance for property owners, the effectiveness of the cap in protecting both property owners and the families of lead-poisoned children and mechanisms to financially assist property owners in lead abatement. The task force is required to report to the joint standing committees of the Legislature having jurisdiction over judiciary and human resources matters by November 1, 1998.

NY **1996 N.Y. Laws, Chap. 279 (S 7884)** enacts the Pesticide Registry Act in order to assess the impact of pesticides on human health through public health research and improved recordkeeping of pesticide use. The act establishes a computerized pesticide database to be made available to the public and to health researchers.

VT **1996 Vt. Acts, Act 165 (H 778)** provides standards to be followed by private and nonprofit owners of rental housing and child care centers in removing or containing lead-based paint hazards under a program funded through a federal grant and a matching state grant. The act establishes a certification process for people who satisfactorily complete a training program in performing essential maintenance practices for lead-based hazard control. The act also specifies essential maintenance practices to be followed by owners for lead-based paint removal or containment. The act creates a duty of reasonable care for owners of rental housing and child care facilities regarding lead-based paint hazards and provides some protection from liability from actions for damages

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arising from lead-based hazards against those owners who comply with the essential maintenance practices and other requirements of the act.

The act also requires the secretary of human services to report to the General Assembly regarding the effectiveness of the requirements of this act and recommendations for additional actions that will further reduce the occurrence of lead poisoning in children.

FINANCING

AL **1996 Ala. Acts, Act 704 (H 327)** makes an appropriation from the Education Trust Fund to the sickle cell education program for the fiscal year ending September 30, 1997.

AZ **1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)** changes the name of the medically needy and medically indigent program stabilization fund to the medical services stabilization fund. The act expands the use of money in the stabilization fund to be used to offset increases in the cost of providing levels of services to those eligible for Arizona Health Care Cost Containment System (AHCCCS) services through federal categories if the increase in costs is caused by a decrease in federal funding. The act makes a one-time transfer of $30 million from the medically needy account tot the medical services stabilization fund.

Subject to the availability of funds in the medically needy account of the tobacco tax and health care fund, the act establishes the premium sharing demonstration project fund and the basic children's medical services program. The AHCCCS administration, contingent on the existence of the fund, is authorized to withdraw $20 million in FY 1996-97, 1997-98 and 1998-99 to be deposited in the fund to provide health care services to those eligible for the AHCCCS Premium Sharing Demonstration Project Implementation Committee to make recommendations to the governor, the Legislature, the secretary of state and the director of the Arizona Legislative Council by November 15, 1996, regarding the implementation of a premium sharing program. The act recommends that the committee address participant eligibility criteria, an income threshold that does not exceed 300 percent of the federal poverty level, the types of services to be provided and the entity that should be responsible for collecting participant premiums. At the direction of the committee, the AHCCCS administration is required to conduct actuarial studies that provide rate and premium sharing cost estimates.

Beginning FY 1996-97, the act, annually transfers up to $5 million to the Department of Health Services (DHS) to establish contracts with eligible hospitals to provide for a basic children's medical services (BCMS) program, to provide health care services to indigent, uninsured or underinsured children who are not eligible for AHCCCS services. Up to two percent of the total funding is authorized to be used for administrative costs and additional money, as necessary, to perform program evaluations. Program money is required to be used to enhance the hospital's ability to provide additional services to eligible children and improve the delivery of inpatient, outpatient and specialized clinical services. The act sets out requirements for participating hospitals, including a sliding fee scale for eligible children.

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. For most AHCCCS recipients, the federal government pays 65 percent and the state pays 35 percent of the costs of health care. Currently, there are many eligibility categories that determine whether an individual can receive health care under AHCCCS, including one requiring that a recipient's net income not exceed approximately 34 percent of the "federal poverty level." Proposition 203 expands eligibility to cover people who earn up to 100 percent of the federal poverty level under AHCCCS.

Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, to be allocated as follows: $5 million to the Healthy Families Program, which provides services to prevent child abuse and neglect and to promote child wellness and proper development; $4 million to the Arizona Health Education System to provide scholarships to medical students who agree to practice in areas of the state that are currently underserved by health care professionals; $3 million to programs to prevent teenage pregnancy; $2 million for disease control research; $2 million to Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children; and $1 million to the Women, Infants and Children Food Program.

Previously, lottery revenues were earmarked for deposit in economic development, local transportation assistance and two state heritage funds. Under Proposition 203, the $17 million will be distributed only after the economic development, local transportation assistance and heritage funds receive their full appropriations.

CA **1996 Cal. Stats., Chap. 50 (SRJ 52)** asks Congress and the president to enact legislation enabling postal stamp patrons to voluntarily donate 1 cent per stamp for supplemental breast cancer research.

CA **1996 Cal. Stats., Chap. 74 (AB 2804)** establishes a special supplemental payment to hospitals that provide a disproportionate share of care to Medi-Cal and other low-income patients. The act limits the total amount of payment to $200 million with the stipulation that it could be less depending on the total amount of federal funds available for this purpose. The act provides that the nonfederal share of these supplemental payments would come from University of California hospitals through a special transfer provision.

CA **1996 Cal. Stats., Chap. 198 (AB 3484)** reduces by $10 million the state fee paid by public hospitals participating in the disproportionate share hospital program.

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the following programs funded by Cigarette and Tobacco Products Surtax Fund money: Comprehensive Perinatal Outreach, selected primary care clinics, Access for Infants and Mothers, County Medical Services Program and emergency treatment of out-of-county indigent patients. The act revises reporting and maintenance of effort requirements under the California Health Care for the Indigent Program.

CA **1996 Cal. Stats., Chap. 529 (SB 1636)** permits a hospital that meets the existing disproportionate share hospital criteria and is designated by the National Cancer Institute as a comprehensive/clinical cancer research facility to participate in the Emergency Services and Supplemental Payments Fund.

CA **1996 Cal. Stats., Chap. 1099 (AB 1184)** increases payments in 1996-97 to disproportionate share hospitals under the Medi-Cal supplemental payments program. The increased payments are made to the extent that total payments do not exceed the $2.2 billion program cap after the initial round of payments, which are based on 80 percent of each hospital's past year Medi-Cal days.

DE **Vol. 70 Del. Laws, Chap. 472 (SB 405)** establishes a Breast Cancer Education and Early Detection Fund. An individual who claims an overpayment of taxes on an income tax return may designate that $1 or more be deducted from the refund and paid to the fund. An individual who has an income tax liability may, in addition to the obligation, include a donation of $1 or more to be paid to the fund. In both cases, the Division of Revenue will forward the designated amounts to Women and Wellness Inc., which must deposit them to the credit of the Delaware Chapter of the National Breast Cancer Coalition to be used for breast cancer education and early detection. From time to time as determined by the Delaware State Clearinghouse Committee, Women and Wellness must submit a report to the committee detailing revenues, expenditures and program measures for the fiscal period in question.

HI **1996 Hawaii Sess. Laws, Act 259 (HB 3493)** establishes a newborn metabolic screening special fund to pay for laboratory testing, follow-up testing, educational materials, continuing education, quality assurance, equipment and indirect costs. The act requires the Department of Health to charge a fee of $4 to birthing facilities for each newborn screening kit from July 1, 1996, to June 30, 1997. When the provision sunsets, funds are to be deposited into the fund. The act also requires the department to convene a panel to develop a plan for providing newborn metabolic services to the community. The department is directed to adopt rules to increase the number of newborn screening tests until the plan is completed. The director of health must make an annual report to the Legislature.

ID **1996 Idaho Sess. Laws, Chap. 410 (SB 1567)** repeals and amends certain sections relating to care for the medically indigent. The act specifies the power and duty of the Board of County Commissioners to provide for the care of medically indigent residents of the county and to provide certain emergency care for nonresidents for the period between July 1, 1996 and June 30, 1997. The act specifies duties of the administrator and authorizes reciprocal agreements with other states. The act provides for a written application for financial assistance and to provide a lien upon application and a schedule to govern the investigation of an application or request. In addition, the act provides a petition for judicial review of a final determination and requires notification of admission and to authorize transfer of a medically indigent person. The act governs the amount to be paid for necessary medical services and to provide for repayment of amounts collected. The act specifies the right of subrogation for the county and the catastrophic health care costs program and the right to govern the method for reimbursement of financial assistance.

IL **1996 Ill. Laws, P.A. 89-506 (HB 22)** creates a Medical Research and Development Fund and a Post-Tertiary Clinical Services Fund, which may receive state appropriations. The first fund is to match federal and private aid for biomedical research, technology and program development at large academic medical centers in the Chicago area and at the SIU School of Medicine and its affiliated teaching hospitals in Springfield. The second fund is to pay subsidies to those hospitals and to the University of Illinois' primary teaching hospitals in Peoria and Rockford, to promote any of 15 kinds of medical therapies or diagnostic methods.

IL **1996 Ill. Laws, P.A. 89-516 (HB 3309)** allows the Illinois Department of Public Health (IDPH) to issue an annual Freestanding Emergency Center demonstration license to a facility meeting several criteria. The center must have at least one board-certified emergency physician and a crew of paramedics present and must offer comprehensive emergency treatment 24 hours a day. The demonstration program will last until September 1998 but may be extended two more years. People convicted of firearm or drug crimes must pay a $100 "fee" to go to the Trauma Center Fund in the state treasury for distribution to hospitals designated as trauma centers.

IL **1996 Ill. Laws, P.A. 89-646 (SB 1513)** allows local governments offering general assistance to choose to pay for medical care for emergency medical treatment, care and supplies only.

IA **1996 Iowa Acts, Chap. 1106 (SF 2324)** relates to public assistance and amends various tax and program provisions associated with the Individual Development Account (IDA) project enacted in the 1993 Legislative Session as part of welfare reform. The IDA project permits low-income persons to maintain individual state tax-exempt accounts under sponsorship of a nonprofit organization. Among other provisions, the act permits authorized withdrawals for certain emergency medical costs.

KY **1996 Ky. Acts, Chap. 26 (HB 363)** allows the Board of Nursing to establish an impaired nurse committee to promote the early identification, intervention, treatment and rehabilitation of nurses who may be impaired by reason of illness, alcohol or drug abuse, or as a result of any physical or mental condition. Beginning January 1, 1997, the board shall collect an assessment of $5 to be added to each nurse licensure renewal application fee payable to the board, proceeds from which shall be expended on the operation of an impaired nurses committee.

KY **1996 Ky. Acts, Chap. 110 (HB 397)** phases out the provider tax on physicians by June 30, 1999.

LA **1996 La. Acts, P.A. 27 (HB 84)** allows a person who maintains a household that includes one or more dependents who are physically or mentally incapable of caring for themselves to take as a credit against the state income tax the full amount of a tax credit equal to the applicable percentage of employment-related expenses allowable under the Internal Revenue Code. The amount of the unused credit may be carried forward to the next tax year.

LA **1996 La. Acts, Sen. Concur. Res. 66** requests the governor, commissioner of administration and secretary of the Department of Health and Hospitals (DHH) to financially support the Medically Needy Program within DHH's Medical Vendor Program for FY 97.

ME **1996 Maine Laws, Chap. 653 (LD 1788)** creates the Maine Health Data Organization (MHDO) to continue the data collection efforts of the Maine Health Care Finance Commission, which expired on June 10, 1996. The act provides for the establishment and duties of the MHDO governing board, with board members representing consumers, employers, payers and providers.

To finance the Maine Health Data Organization during the transition, the act allows all hospitals except state hospitals to be assessed not more than .07 percent of their gross patient revenues, not to exceed $775,000 for all hospitals. Each hospital must pay the assessment quarterly. The act requires the board to submit legislation to establish fees and assessments for permanent funding.

In order to conduct quality improvement research, the board is authorized to designate a quality improvement foundation if the board finds that the foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and has protocols to safeguard confidential and privileged information.

The act amends and reenacts provisions governing comprehensive health planning. The act requires that the Department of Health adopt a state health plan before January 15, 1997 and review it every year after 1997. The plan must identify the state's health care, facility and human resource needs, the resources available to meet those needs and recommendations for addressing those needs statewide.

The act directs the Department of Health to adopt reasonable charity care guidelines for hospitals. The department must adopt income guidelines that are consistent with the guidelines applicable to the federal Hill-Burton Program. The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. The guidelines must include provisions for notice to the public and the opportunity for a fair hearing regarding eligibility for charity care. (See the "Access and Reform" chapter for a more detailed summary of this act.)

ME **1996 Maine Laws, Chap. 697 (LD 1764)** requires that any money identified as savings due to the closure of a state mental health facility or a diminution of services at any such facility and any money from administrative savings at the Department of Mental Health, Mental Retardation and Substance Abuse Services be used to provide those services in other appropriate settings and programs. The act defines these savings as net general fund savings generated through legislative or departmental actions less any cost or liability from implementing those actions.

MD **1996 Md. Laws, Chap. 273 (HB 798)** establishes the Health Resources Planning Commission Fund to be used by the Health Resources Planning Commission. The act authorizes the commission to determine compensation for certain officers of the commission and addresses user fees, personnel and funding.

MA **1996 Mass. Acts, Chap. 203 (HB 6107)** expands Medicaid eligibility for children under age 12 with family incomes under 200 percent of poverty. The act authorizes Medicaid benefits to be provided by means of a demonstration project known as MassHealth. The act also expands eligibility for the Children's Medical Security Plan to children from the current age 12 to 18, which covers Medicaid ineligible children on a sliding scale. The act increases the cigarette tax to 25 cents per pack, which also applies to cigars and pipe tobacco, to help fund both program expansions.

MS **1996 Miss. Laws, Chap. 496 (H 1187)** amends current law to specify that all University of Mississippi Medical Center locations provide not less than 50 percent of their services to indigent people, including qualified beneficiaries of the state Medicaid Program. The act also authorizes the teaching hospital and related facilities to establish and operate managed care plans and to enter into group purchasing arrangements.

MS **1996 Miss. Laws, Chap. 505 (S 2031)** establishes a system of treatment for people with spinal cord or traumatic injuries, to be implemented by the state Department of Rehabilitation Services. The act creates a spinal cord and head injury trust fund to provide the cost of treatment and rehabilitation, funded by a $4 assessment for moving traffic violations and a $25 assessment for violations of the implied consent law.

NE **1996 Neb. Laws, L.B. 1188** requires the Department of Health to approve or disapprove any proposed acquisition of a hospital by a for-profit hospital or other group."Acquisition" is defined as a transaction that results in a change of at least 20 percent of the ownership or controlling interest in a hospital or that results in the acquiring party owning or controlling at least 50 percent of the hospital. The act provides that all documents related to the application for acquisition be public records. Public notice of the application in a newspaper and a public hearing are also mandated.

The act also requires notification to the attorney general of a proposed nonprofit hospital sale by a for-profit entity and the attorney general may, but is not required to, review and approve or disapprove the proposal. The decision by the Department of Health and attorney general if applicable, must be made within 60 days after receipt of the acquisition application.

If the two nonprofit entities have substantially similar charitable health care purposes, a transfer between two nonprofit hospitals is exempt from state review.

NJ **1996 N.J. Laws, Chap. 28 (AB 1532)** provides $310 million for indigent care payments to hospitals for 1996 and $300 million in 1997, down from $400 million that was available in 1995. Funds will still be used from the unemployment fund. The law also authorizes the commissioner of the Department of Health to submit a waiver to the federal government in order to allow New Jersey to use disproportionate share payments for a managed care-type plan for charity care. The law also funds the hospital health care subsidy account that provides payments to hospitals that treat a large amount of AIDS, TB, low-birth weight babies, drug and alcohol abuse and other public health problems. The subsidy account is funded at the same level as the last two years.

NM **1996 N.M. Laws, Chap. 29 (HB 298)** amends various statutes related to county indigent health care. The County Local Option Gross Receipts Taxes Act is amended to require that funds raised from the second one-eighth and 50 percent of the third one-eighth be placed in the county indigent hospital claims fund and spent according to the Indigent Hospital and County Health Care Act. This provision will prevent the diversion of county indigent funds to non-health care related initiatives. The Statewide Health Care Act is amended to allow for funds from the nine percent set aside from the county-supported Medicaid fund to be used to support existing primary care facilities and establish new primary care facilities. The Rural Primary Health Care Act is also amended to define "eligible programs" as nonprofit community-based entities providing or committing to provide primary health care services. This change will allow communities greater flexibility to use existing entities to provide primary care services. Finally, the act extends the reversion date by two years, until 1998, for counties to transfer balances of funds from the county indigent hospital claims fund to the county-supported Medicaid fund.

NM **1996 N.M. Laws, H. Jt. Mem. 20** requests that the New Mexico health policy commission, in cooperation with the Department of Health, the Human Services Department and the Department of Insurance, study and propose options to improve access to comprehensive health care by better use of existing public and private funds. The study is to include current federal, state and local fiscal resources and how they can be realigned to improve health care purchasing and delivery; publicly funded insurance programs and how restructuring can improve quality and access to insurance; roles and responsibilities of the private sector and state and local governments; processes to involve the public, advocates and providers in health care spending and benefit decisions; and how private health care dollars can be leveraged with public dollars to provide more services to the uninsured.

NY **1996 N.Y. Laws, Chap. 253 (S 7537-A)** indefinitely continues the child health insurance program (Child Health Plus) and the regional pilot projects for the uninsured by removing the sunset date of June 30, 1996 for each program. The act authorizes the continuation and amendment of any contractual arrangements with approved organizations to provide coverage for eligible individuals in effect on that date in order to provide an uninterrupted continuation of services. The act stipulates, however, that these programs will remain in effect only as long as funds continue to be available.

The act makes available to the commissioner of health, for distribution to these two programs, funds accumulated in pool reserves for regional or statewide pools, as well as certain funds accumulated in the health care planning account during the period January 1, 1996, to June 30, 1996. The act authorizes the commissioner, for cash flow purposes, to allocate funds accumulated for distribution from certain other specified pools to the pool reserves in order to pay the premiums for the continuation of Child Health Plus and the regional pilot projects and requires the commissioner to refund this money when pool reserve funds become available. Finally, the act extends for another year, until June 30, 1997, the excess medical malpractice liability insurance program (see Chap. 639 for other information related to the Child Health Plus Program).

NY **1996 N.Y. Laws, Chap. 279 (S 7884)** creates a Health Research Science Board in the Department of Health (DOH) and establishes the Breast Cancer Research and Education Fund with personal and corporate income tax checkoffs dedicated to the fund. The act adds language to the corporate franchise tax and personal income tax law to permit a taxpayer or individual to contribute a financial gift to the Breast Cancer Research and Education Fund by checking the appropriate space provided on the tax return. The act declares that a donation will not reduce the amount of tax owed and that all revenues collected according to these provisions must be credited to the Breast Cancer Research and Education Fund and used only for those purposes.

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which continues only until December 31, 1996, existing provisions of the state's hospital reimbursement rate-setting law. The acts continue beyond 1996 until December 31, 1999, the same rate-setting methodology only for Medicaid and certain other payers. The acts deregulate the payment system for most other payers, on and after January 1, 1997, by allowing them to negotiate with hospitals to establish their own payment rates.

The acts establish a number of new provisions for the financing of "public goods programs" on and after January 1, 1997. Insurers and other payers must pay allowances on payments for services rendered, as well as per-person payments for each individual or family member covered by the insurer ("covered lives assessments"), which go into a pool to fund the public goods programs. Funds from these payments, as well as certain Medicaid funds and other payments, are used to finance the costs of graduate medical education, various insurance programs for the uninsured, primary care development, emergency medical services training and health facility restructuring and provider networking programs designed to assist providers in adapting to the changing health care environment.

For example, the acts authorize the commissioner of health to distribute funds in the health care initiatives pool for the Child Health Plus Program ($120 million in 1997, $164 million in 1998 and $181 million in 1999), the Small Business Health Insurance Partnership Program, the Voucher Insurance Program, the Individual Subsidy Program, the Catastrophic Health Care Expense Program, the Primary Health Care Services Pool and the Primary Care Education and Training Program (including the loans, scholarships and medical education grants for minority participation).

The acts make permanent the Child Health Plus Program, through which primary and preventive health services are provided to eligible children, expand the program by increasing the age limit for eligibility, add coverage for hospital and related inpatient services and make several other changes. Participating insurers must impose a copayment of $2 per visit for physician services, in addition to the other copayments and coinsurances for which insurers are permitted to require payment.

The acts increase the required family contribution toward the premium costs for children's coverage, concurrently with the addition of inpatient services on January 1, 1997, to make such payments vary based on the relationship of the family's net income to the non-farm federal poverty level (FPL), as follows: for income less than the FPL, no payments; for income 100 percent to 132 percent of FPL, payments of $9 monthly per eligible child (with a maximum per family of $36 monthly); and for income 133 percent to 185 percent of FPL, $13 monthly per eligible child (family maximum $52 monthly).

The acts establish a new program entitled the "New York State Small Business Health Insurance Partnership Program," administered by DOH, to assist eligible employers in purchasing small group health insurance or comprehensive health services plan coverage for employees and their dependents. The program applies to employers of less than 50 full-time employees (those who work at least 20 hours per week), which have not provided group health insurance benefits to any employees for the past 12 months.

The acts authorize the superintendent of insurance, in conjunction with the commissioner of health, to conduct a demonstration program to assist eligible individuals and families in purchasing health care coverage from approved insurers and make this program available to individuals and families who can adequately document that: they reside in specific areas designated by the superintendent; their gross household family income does not exceed 122 percent of the non farm federal poverty level; and they are not eligible for Medicaid or Medicare, do not have equivalent health care coverage and have not had equivalent coverage within the 12-month period before application, with exceptions. Vouchers may be provided to such individuals and families and the vouchers may then be submitted to participating insurers in order to obtain coverage.

The acts allow Rural Health Network Development Grants to be used to support activities and organizational costs, including the recruitment of qualified health care professionals, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community-based primary care systems and the integration and expansion of prehospital emergency medical services. The acts create a new "Rural Health Care Access Development Program," through which grants and financial assistance can be provided to general hospitals classified as rural hospitals under federal or state regulations, in recognition of the unique costs incurred by these facilities in providing hospital services in remote or sparsely populated areas.

The acts require each hospital's performance in meeting the health care needs of the community, providing charity care services and improving access to health care services by the underserved.

OK **1996 Okla. Sess. Laws, Chap. 86 (SB 999)** allows counties and municipalities to jointly create a hospital authority for the purpose of planning, financing and constructing hospital or related medical facilities. A hospital authority may levy a sales tax, not to exceed 2 percent, upon voter approval in each of the local governments comprising the authority.

OK **1996 Okla. Sess. Laws, Chap. 264 (SB 810)** transfers from the University Hospitals Authority of the University Hospitals Trust, upon closing of an agreement for the operation of the hospitals, $15 million to cover anticipated startup costs of the proposed joint venture with Columbia/HCA and any severance costs for former state employees that the trust may incur due to an agreement with a private entity.

OK **1996 Okla. Sess. Laws, Chap. 321 (HB 2497)** concerns the proposed joint venture with Columbia/HCA to operate the University Hospitals and adjacent Presbyterian hospital. The measure requires any agreement to contain an independent statement as to the fairness of the contract to the state and assigns responsibility for overseeing the agreement to the University Hospitals authority. The act also creates a University Hospitals Trust Legislative Advisory Task Force.

OK **1996 Okla. Sess. Laws, Chap. 326 (SB 811)** establishes certain mandates for any agreements that the University Hospitals Trust might enter into with a private entity for operation of the University Hospitals, including that all major decisions be approved by a majority of the state appointees to the governing entity.

OR **Measure 44, 1996 General Election (ballot initiative)** increases the state's cigarette tax from 1.4 to 2.9 cents per cigarette, with the majority of the tax going to the Oregon Health Plan for tobacco use reduction programs. The measure adds one-time taxes totaling 3 cents per cigarette, with proceeds to go to the Oregon Health Plan, tobacco use reduction. The measure also retains the .5 cent per cigarette tax that funds Oregon Health Plan, to maintain and expand the number of people eligible for medical assistance.

RI **1996 R.I. Pub. Laws, Chap. 100 (HB 8783)** authorizes the Department of Human Services to amend its regulations and fee schedules and the Rhode Island State Plan for Medical Assistance (Medicaid) to limit reimbursement to in-state and out-of-state hospitals for inpatient services provided to eligible persons in accordance with this act. Inpatient hospital services reimbursement limited to $75,000 per admission, except for organ transplant admissions. The act established the rates of reimbursement to hospitals for outpatient services to eligible recipients equal to 60 percent of the hospital's ratio of costs to charge such services. The act increases RIte Care transition payments to community health centers from $10 to $15 per member per month and designates that payment be made through Rhode Island Health Center Association Inc.

The act addresses uncompensated care and the reimbursement hospitals are eligible to receive for treating patients without coverage. The act states that preservation of the ability of the private acute care hospital system of the state to continue to support an increasing uncompensated care burden is of critical importance to the public health and welfare of the citizens of Rhode Island and that implementation of the section of the Social Security Act that permits the federal government to share in the provision of payments to hospitals that provide a significant amount of uncompensated care is an effective way for the state to assist hospitals in continuing to provide uncompensated care.

RI **1996 R.I. Pub. Laws, Sen. Res. 87** resolves that the Senate of the state of Rhode Island and Providence Plantation request the attorney general to initiate action against tobacco companies that would result in reimbursement to the state for the costs incurred by the Medicaid program for expenses related to the prevalence of smoking among the Medicaid population, which will not only lead to health care cost savings, but also may improve the quality of life of Rhode Island's citizens.

SC **1996 S.C. Acts, Act 390 (H 3915)** grants to the board of trustees of the Medical University of South Carolina (MUSC) the authority to enter into reasonable agreements to transfer the management and operation of the Medical University Hospital to one or more private operators, subject to certain conditions. The act states that no lease or other agreement will be valid unless the Budget and Control Board certifies full compliance with the provisions of this act. A private operator must provide indigent care in the same manner as now provided by MUSC. In addition, MUSC must maintain the level of services currently offered to indigent patients at Charleston Memorial Hospital, unless the board decides otherwise. For discontinuation or transfer of any inpatient clinical service offered at the Medical Center, the law requires prior written consent of the board of trustees.

Access for anyone or group to use the services of the Medical University Hospital and clinical services must not be limited, restricted, denied, or allowed in a discriminatory manner prohibited by law, nor must access be denied based on lack of participation or membership in a particular health plan or network.

This act ensures MUSC retains access at all times to all records of all patients treated at the Medical University Hospital and all patients retain access at all times to their own records.

UT **1996 Utah Laws, Chap. 108 (HB 129)** creates a Medicaid restricted account and states that any general funds appropriated to the Department of Health for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and are not otherwise designated as nonlapsing will lapse into the Medicaid restricted account. The act allows the legislature to appropriate money in the restricted account to fund programs that expand medical assistance coverage and private insurance plans to low-income persons who have not traditionally been serviced by Medicaid.

UT **1996 Utah Laws, Chap. 276 (HB 404)** provides a tax deduction of 60 percent of the amounts paid by the taxpayer during the taxable year for health care insurance for the taxpayer and his or her spouse and dependents to the extent the amounts paid for health insurance were not deductible under the federal Internal Revenue Code. The act clarifies that a deduction is not allowed for amounts that are reimbursed or funded in whole or in part by government and for a taxpayer who is eligible to participate in a health plan that is funded in whole or in part by the taxpayer's employer. The deduction is allowed for tax years beginning on or after January 1, 1996.

UT **1996 Utah Laws, Chap. 332 (SB 225)** requires family support services and associated case management services offered by the Division of Services for People with Disabilities be provided through vouchers or direct financial assistance. A voucher describes the services and supports that may be received and lists approved providers that may be used by a person with a disability or his parent or guardian to purchase services and supports. The voucher also includes a maximum dollar value, states the period of time within which the voucher must be used and is redeemable by an approved provider for payment by the division up to the dollar value of the voucher. The division must conduct an evaluation of the effects of providing vouchers and direct financial assistance under this act and report the results to the Human Services Interim Committee before December 31, 1998. To implement this act with regard to Medicaid funds, the Division of Health Care Financing within the Department of Health, in cooperation with the Division of Services for People with Disabilities is directed to submit an amendment to the state's Medicaid home- and community-based services waiver.

VT **1996 Vt. Acts, Act 152 (H 282)** provides for recovering medical payments made by Medicaid from a third party. The act states that Medicaid is the payer of last resort; that Medicaid pays only after payment is made by any and all third parties, including Medicare, health insurance, medical coverage provided in conjunction with other compensation programs, such as worker's compensation, support settlements, trust funds or any party determined to be liable in a negligence action that results in an agreement or judgment.

HEALTH PROMOTION

DE **Vol. 70 Del. Laws, Chap. 472 (SB 405)** establishes a Breast Cancer Education and Early Detection Fund. An individual who claims an overpayment of taxes on an income tax return may designate that $1 or more be deducted from the refund and paid to the fund. An individual who has an income tax liability may, in addition to the obligation, include a donation of $1 or more to be paid to the fund. In both cases, the Division of Revenue will forward the designated amounts to Women and Wellness Inc., which must deposit them to the credit of the Delaware Chapter of the National Breast Cancer Coalition to be used for breast cancer education and early detection. From time to time as determined by the Delaware State Clearinghouse Committee, Women and Wellness must submit a report to the committee detailing revenues, expenditures and program measures for the fiscal period in question.

DE **Vol. 70 Del. Laws, H. Res. 86** encourages and requests the Division of Public Health of the Department of Health and Social Services to provide leadership in the promotion of public awareness and knowledge about the diagnosis, prevention and treatment of osteoporosis.

FL **1996 Fla. Laws, Chap. 217 (SB 322)** amends current law regarding smoking to prohibit smoking on, in, or near school property. The act authorizes certain law enforcement officers to issue citations for violations and provides a civil penalty.

FL **1996 Fla. Laws, Chap. 282 (HB 397)** establishes the osteoporosis prevention and education program within the Department of Health and Rehabilitative Services to be administered by the State Health Office, in consultation with the Department of Elderly Affairs. The act requires health plans to cover osteoporosis screening, diagnosis, treatment and management. The act amends the list of exemptions to include certain group health insurance policies that are issued or delivered outside the state.

FL **1996 Fla. Laws, H. Res. 9057** recognizes the week of March 17-23, 1996, as Poison Prevention Week.

FL **1996 Fla. Laws, H. Res. 9241** designates October 1996 as Breast Cancer Awareness Month.

FL **1996 Fla. Laws, Sen. Res. 1824** recognizes April as "Early Intervention Awareness Month" and urges all residents to support the state's early intervention programs and services that promote healthy environments and optimal development for children.

FL **1996 Fla. Laws, Sen. Res. 2894 and H. Res. 9053** proclaim the week of April 21-27, 1996, as Florida Infant Immunization Week.

HI **1996 Hawaii Sess. Laws, S. Res. 151 and H. Res. 152** affirm the vital role that the governor's Pacific Health Promotion and Development Center plays in improving Pacific Islander and Hawaiian health and respectfully requests the governor to continue to provide support for the center's activities.

MD **1996 Md. Laws, Chap. 365 (SB 59)** requires each hospital to offer mammography educational materials to each female patient when medically appropriate for the patient. The Department of Health and Mental Hygiene, in collaboration with specified entities, must select and approve or develop and print and update as necessary, the materials.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following: from the state funds appropriated for the center for health promotion, the department must allocate funds to promote awareness, education and early detection of breast, cervical and prostate cancer and provide for other health promotion medical activities.

OR **Measure 44, 1996 General Election (ballot initiative)** increases the state's cigarette tax from 1.4 to 2.9 cents per cigarette, with the majority of the tax going to the Oregon Health Plan for tobacco use reduction programs. The measure adds one-time taxes totaling 3 cents per cigarette, with proceeds to Oregon Health Plan, tobacco use reduction. The measure also retains one-half cent per cigarette tax that funds Oregon Health Plan, to maintain and expand the number of people eligible for medical assistance.

PA **1996 Pa. Laws, Act 87 (HB 216)** establishes, among other positions, the Office of Physician General within the Department of Health and provides that the physician general will be appointed by the governor, by and with the advice and consent of the Senate. The physician general, who must be a practicing physician, is to advise the governor and the secretary of health on health policy; participate in the decision-making process of the department on policies relating to all medical and public health-related issues and in the decision-making process of other executive branch agencies as directed by the governor, review professional standards and practices in medicine and public health; consult with recognized experts on medical and public health matters; coordinate educational, informational and other programs for the promotion of wellness, public health and related medical issues and serve as the primary advocate for such programs; and consult with experts in the state and other states regarding medical research, innovation and development.

WV **1996 W. Va. Acts, Chap. 135 (HB 4198)** creates the Osteoporosis Prevention Education Act and requires the Bureau of Public Health to promote and maintain the program, which is to include strategies for educating the public and health professionals. The act also establishes the Interagency Council on Osteoporosis to coordinate osteoporosis programs conducted by the Bureau of Public Health.

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IMMUNIZATION

AZ **1996 Ariz. Sess. Laws, Chap. 228 (HB 2134)** requires a health care professional licensed to provide immunizations to report specific identifying and health information to the Department of Health Services (DHS) for the purpose of entering the data into the child immunization reporting system. DHS is required to provide a form to allow parents to opt out of the reporting system. The act specifies to whom DHS may release a child's identifying information and authorizes DHS to adopt rules regarding the release of immunization information to persons for a specified purpose. The act authorizes DHS to release non-identifying summary statistics. The act allows health care professionals to submit the information to DHS on a weekly or monthly basis by phone, fax, mail, computer or other means and specifies that the information in the system is confidential.

CA **1996 Cal. Stats., Chap. 556 (SB 686)** requires health plans and insurers to add immunization coverage for children consistent with the most current version of the Recommended Childhood Immunization Schedule of the United States to the benefits offered to subscribers.

CO **1996 Colo. Sess. Laws, Chap. 127 (HB 1176)** allows a parent or other person responsible for the care and custody of a minor, other than a licensed child care center employee, to delegate that person's authority to consent to the immunization of a minor to certain persons. The law limits the practitioner's liability for damages resulting from factual errors in health information given when such practitioner reasonably relies upon the information given and exercises reasonable and prudent care in administering the immunization. The law similarly limits the liability of the facility at which the immunization is administered.

FL **1996 Fla. Laws, Chap. 195 (SB 1860)** prohibits certain health insurance policies that provide maternity and newborn coverage from limiting coverage for the length of a maternity and newborn stay in a hospital and requires follow-up services to include physical assessment of the newborn and mother and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

FL **1996 Fla. Laws, Sen. Res. 2894 and H. Res. 9053** proclaim the week of April 21-27, 1996, as Florida Infant Immunization Week.

GA **1996 Ga. Laws, p. 799 (H 844)** establishes a childhood vaccination registry. Anyone who administers a vaccination to a child 18 years or younger must provide the Department of Human Resources with information on the type of vaccination, date administered and possible side effects.

KS **1996 Kan. Sess. Laws, Chap. 229 (HB 2900)** grants specified persons authorization to disclose the immunization status of those against childhood diseases without parental consent. A written objection, on religious grounds, to the disclosure of immunization information will prevent the disclosure unless there is a written release authorizing such disclosure.

KY **1996 Ky. Acts, Chap. 306 (HB 588)** requires immunizations of children against measles, mumps, hepatitis B and haemophilis influenza disease in addition to those currently required under state law and allows additional immunizations to be required by the state if recommended by the U.S. Public

Health Service or the American Academy of Pediatrics. The act requires a current immunization certificate to be on file for any child enrolled in a public or private primary or secondary school and preschool program within two weeks of the child's attendance, rather than before attendance; requires a current immunization certificate to be on file for any child cared for in a day care center, certified family child care home, or any other licensed facility which cares for children. The act also requires that any forms related to exemption from immunization requirements be available at public or private primary or secondary schools, preschool programs, day care centers, certified family child care homes, or other licensed facilities that care for children.

MA **1996 Mass. Acts, Chap. 334 (HB 5791)** transfers the biologic laboratories of the state laboratory institute from the Department of Public Health to the University of Massachusetts. The purpose of these labs is to research, develop and produce childhood vaccines and biologic products designed to reduce or prevent morbidity and mortality, including but not limited to those products which may be of little or no interest to commercial manufacturers and are therefore substantially unavailable to the citizens of the commonwealth.

MI **1996 Mich. Pub. Acts, Act 399 (HB 5094)** amends the immunization requirements pertaining to children in public schools. Students entering for the first time who haven't received the necessary immunizations may submit a statement signed by a physician that certifies that the child is in the process of complying with all immunization requirements. The act also requires the administrator of each school to provide the director of community health with the immunization status of each pupil in grades K through 12 who enrolled in the school for the first time between the immediately preceding January 1 and the immediately preceding September 30. Not later than February 1 of each year, the administrator of each school must provide an update to the report due the previous November 1 to show the immunization status of each pupil in grades K through 12 who enrolled in the school for the first time during the calendar year ending the immediately preceding December 31.

MI **1996 Mich. Pub. Acts, Act 540 (HB 5477)** requires the Department of Health to establish a childhood immunization registry to record information regarding immunizations. The information contained in the childhood immunization registry is subject to confidentiality and disclosure requirements and the department may use the information only for immunization purposes.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** requires the commissioner of health to submit recommendations to the Legislature and governor (by January 15, 1997) relating to Minnesota immunization law and policy regarding vaccine-preventable diseases for which immunization is not currently required by law, including, but not limited to, hepatitis A, hepatitis B, varicella (chicken pox) and other vaccine-preventable diseases identified by the commissioner.

MN **1996 Minn. Laws, Chap. 465 (HF 219)** amends provisions governing mandated coverage for children's health supervision services. The act extends current immunization coverage requirements and mandates coverage for immunization for children from birth to age six. The act requires that all health plans providing coverage to a Minnesota resident, issued, renewed, or continued on or after August 1, 1996, provide coverage for appropriate immunizations to children from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics.

MO **1996 Mo. Laws, p. 379 (HB 904)** requires health insurers and similar entities to cover immunizations of children under the age of five. The Department of Health is required to promulgate rules that specify what immunizations are covered. The coverage is not subject to deductible or copayment limits.

The act adds hepatitis B to the list of immunizations that are required for school attendance. The department is allowed to modify this list by rule and regulation. The act also allows children to be immunized based on the consent of an adult who is not the child's parent or guardian. The adult is allowed to consent if the parent has delegated to the adult in writing the authority to consent to the immunization or if the location of the parent is unknown. The adult is prohibited from consenting to the immunization if the adult has knowledge that the parent would refuse to consent to the immunization. The adult is also required to give the health care provider the health information about the child or the child's family that is necessary to decide whether the immunization is advisable. The adult is given limited immunity from liability for damages resulting from the immunization.

NY **1996 N.Y. Laws, Chap. 61 (S 314-A)** requires local social services districts to provide all applicants and recipients of public assistance with children age five or younger with information and a schedule regarding age-appropriate immunizations for children in accordance with the recommendations of the Department of Health and the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services. The telephone number of the local county health department must be included. The act directs the commissioner of social services, in consultation with the commissioner of health, to require each district to provide applicants and recipients information about their eligibility for free vaccinations for their children.

NY **1996 N.Y. Laws, Chap. 62 (S 468)** directs the commissioner of health to establish an immunization schedule for newborns that charts out recommended immunizations against certain diseases and illnesses as well as age-appropriate times for the administration of each. The act requires that the schedule include information on the importance of getting children immunized at the recommended ages and a toll-free telephone number operated by the Department of Health as part of its immunization education efforts. The schedule must be in accordance with recommendations establishes by the department and by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services. The act directs the commissioner to provide the schedule to local registrars of vital statistics, who must furnish it without charge to the parents or guardian of a child, or to the mother at the address designated by her, at the same time as a certified copy of the birth certificate for the child is furnished.

PA **1996 Pa. Laws, Act 15 (HB 1578)** enacts the Hepatitis B Prevention Act and requires the Department of Health to establish a statewide program for the prevention of hepatitis B through immunization of children consistent with the recommendations of the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDC). The secretary of health must add hepatitis B to the list of diseases that require immunization for entry into school after August 1, 1997, consistent with the recommendations of the CDC.

SD **1996 S.D. Sess. Laws, Chap. 214 (SB 263)** provides that a patient's immunization record may be shared with health care providers, health care facilities, health agencies, schools and other facilities unless the patient's signed refusal to release the information is in the patient's medical record.

VA **1996 Va. Acts, Chaps. 67 and 533 (SB 115 and HB 1499)** remove the requirements that certain health care providers must obtain written parental consent before sharing immunization and child locator information as a part of the development of the immunization tracking system. This information may only be shared among health professionals for the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations. Currently, written parental consent is required before health professionals may share such information, which often creates a major barrier to ensuring that children are immunized against preventable communicable diseases.

WI **1996 Wis. Laws, Act 222 (SB 239)** requires an annual report to the legislature on the success of the statewide immunization program annually, by July 1.

INJURY PREVENTION

AL **1996 Ala. Acts, Sen. Jt. Res. 101** designates the week of May 19-25, 1996, as Emergency Medical Services Week and acknowledges emergency medical services specialists for many activities including that they save hundreds of lives not only with their medical assistance, but also with their prevention message: they remind citizens about the dangers of drinking and driving, about the importance of wearing safety belts, about using safety belts for our children, about the necessity of motorcyclists wearing helmets and about becoming alert pedestrians.

CT **1996 Conn. Acts, P.A. 96-167 (HB 5351)** requires drivers to stop at least 10 feet from a location with a school crossing guard when directed by the guard and remain stopped until the guard directs them to proceed. Failing to stop as directed can be penalized by a fine of $100 to $500 for the first offense and by a fine of $500 to $1,000, imprisonment for up to 30 days, or both, for subsequent offenses.

FL **1996 Fla. Laws, Chap. 185 (SB 2370)** requires a bicycle rider who carries a small child as a passenger to provide certain safety equipment. The act prohibits a bicycle rider from allowing a passenger to remain in a child seat or carrier when the rider is not in immediate control of the bicycle. The act requires bicycle riders or passengers under the age of 16 to wear bicycle helmets. Finally, the act provides for assessment of fines for certain violations of bicycle safety requirements.

FL **1996 Fla. Laws, Chap. 187 (SB 336)** requires certain persons who operate certain vessels to obtain boating safety identification cards. The act prohibits rental of vessels or personal watercraft to certain persons under specified circumstances. The act requires display of certain information on boating safety and provides penalties.

FL **1996 Fla. Laws, Chap. 246 (HB 341)** specifies in statute certain safety and health standards for transportation of public school students, including that bus drivers must be of good moral character, be able-bodied and sufficiently strong to handle the bus with ease. Drivers are also subject to testing for use of controlled substances.

FL **1996 Fla. Laws, H. Res. 9057** recognizes the week of March 17-23, 1996, as Poison Prevention Week.

HI **1996 Hawaii Sess. Laws, H. Res. 79 and H. Concur. Res. 74** ensure the safety of children during school bus pick up and drop off by requesting the Department of Education to convene a School Bus Safety Task Force to recommend an action plan to implement a school bus safety program for Kauai.

ID **1996 Idaho Sess. Laws, Chap. 147 (SB 1439)** requires the director of the Department of Health and Welfare to establish a statewide poison control center that provides 24-hour emergency telephone referral of poison victims, information to health professionals involved in management of poisoning and overdose victims and community poison prevention education programs. The director must establish a system for consulting with other state agency programs concerned with poisons and poisonings to develop the most coordinated and consistent response possible.

IN **1996 Ind. Acts, P.L. 249 (SB 18)** provides that until July 1, 2001, a person who is less than 15 years of age and who, before March 15, 1995, passed a boating education course approved by the Department of Natural Resources may operate a motorboat.

MD **1996 Md. Laws, Chaps. 401 and 402 (SB 473/HB 897)** require anyone transporting a child under the age of four or weighing less than 40 pounds to secure the child in a child safety seat in accordance with the manufacturer's instructions. A person may not transport a person under the age of 16 years unless that person is secured in a child safety seat or a seat belt.

MA **1996 Mass. Acts, Chap. 144 (SB 1318)** requires school buses to have their headlights illuminated while in operation.

MA **1996 Mass. Acts, Chap. 214 (HB 1925)** designates October as Head Injury Awareness month.

MA **1996 Mass. Acts, Chap. 303 (HB 5761)** authorizes the Boston commissioner of transportation to establish "safety zones" on, at or near any public or private way that is not a state highway (and with approval if the same is a state highway). Safety zones shall be posted as having a speed limit of 20 miles per hour.

MI **1996 Mich. Pub. Acts, Act 574 (HB 5847)** provides that if a school is located in an area that requires school children to cross a state trunk line highway or county highway that has a speed limit of 35 miles per hour or more to attend that school, the school superintendent may submit a request to the state transportation commission or local authority for a school crossing.

MN **1996 Minn. Laws, Chap. 396 (HF 2834)** prohibits children under age 13 from operating personal watercraft, or Jet Ski-style machines, effective May 1, 1996. Children under age 12 are barred from operating motorboats of more than 75 horsepower. Children under age 12 may operate boats from 25 to 75 horsepower if there is someone aged 21 or older within immediate reach of the controls. Those children may operate boats of less than 25 horsepower without supervision.

MS **1996 Miss. Laws, Chap. 545 (HB 1123)** prohibits those under 12 years of age from operating a motorboat without a certificate of completion of a boating safety course and requires a person who is at least 21 years of age to accompany the operator of a motor boat who is under 12 years of age. The act also requires those under age 16 to complete a course in boating safety conducted or approved by the Department of Wildlife, Fisheries and Parks in order to be permitted to operate a motorboat.

NH **1996 N.H. Laws, Chap. 19 (HB 1146)** authorizes the commissioner of safety to adopt rules relative to school bus driver qualification files, school bus operation and school bus accident reports and authorizes the state board of education to adopt rules relative to school bus safety. School districts must instruct all pupils who are transported by the district in the evacuation procedure for buses in emergency situations and any other matters regarding the safety of pupils being transported to school.

NJ **1996 N.J. Laws, Chap. 15 (SB 662)** clarifies several amendments made to the law concerning the operation of power vessels by those under 16 years of age. The act allows those under 16 years of age who have completed an approved boat safety course before July 1, 1996, to operate a power vessel on the waters of the state, provided all other requirements are met. Those under 16 years of age who were issued a boat operator's license before July 1, 1996, may continue to operate a power vessel until the expiration date of the license.

NY **1996 N.Y. Laws, Chap. 16 (S 5753)** makes technical amendments to provisions enacted in 1995 relating to safety requirements in the manufacture, sale and use of in-line skates to prevent serious injury from their use. Effective January 1, 1997, the act prohibits the manufacture, assembly, or sale of in-line skates unless each pair that contains a user's guide or buyer's instruction manual also contain a warning instruction. The act prohibits anyone or legal entity from selling, offering for sale, or distributing in-line skates unless the skates conform to the requirements of the act and protective gear is sold on the same premises.

NY **1996 N.Y. Laws, Chap. 26 (S 380)** establishes penalties for offenses related to operating a school bus carrying at least one student passenger while the ability to drive is impaired by drugs or alcohol.

NY **1996 N.Y. Laws, Chap. 156 (S 193-B)** requires every commercial business that provides its customers with shopping carts with seats for children to equip and maintain not less than 25 percent of the total number with a child protective device, defined as a strap, device, or piece of equipment, utilizing reasonable engineering standards, to prevent a child from falling out of the shopping cart.

NY **1996 N.Y. Laws, Chap. 244 (S 6237-A)** permits a person under the age of 12 to wear a type III U.S. Coast Guard-approved personal floatation device of an appropriate size in lieu of a type I or type II device as otherwise required while the child is participating in an adult-supervised sail instruction or sailboat racing activity.

NY **1996 N.Y. Laws, Chap. 372 (S 4857)** increases the fine for a first conviction for passing a stopped school bus from $150-$250 to $250-$400. The act requires the commissioner of motor vehicles, in consultation with the State Education Department, to prepare and implement a program to educate the motoring public of the increase in fines and the dangers to school children that result from drivers who do not stop for stopped school buses.

NY **1996 N.Y. Laws, Chap. 585 (S 7710)** amends provisions requiring children under 12 years of age on a Class A, 1 or 2 vessel to wear a type I or II personal floatation device, to provide that when the vessel is operated on an inland river or lake other than Lake Erie or Lake Ontario, or the state barge canal system, that children also may wear a type III personal floatation device.

NY **1996 N.Y. Laws, Chap. 656 (S 339-A)** expands the scope of the commissioner of transportation's power to regulate the safety of school buses to include all motor vehicles transporting passengers under the age of 21 from schools and community residences to school programs approved by the state education department.

OK **1996 Okla. Sess. Laws, Chap. 252 (SB 1071)** requires every public school to establish a Safe School Committee to make recommendations to the principal for student safety.

OK **1996 Okla. Sess. Laws, Chap. 337 (SB 1215)** prohibits those under age 12 from operating personal watercraft on public waters.

PA **1996 Pa. Laws, Act 4 (SB 725)** amends the Amusement Ride Inspection Act to require amusement ride owners or lessees to submit an accident report to the Department of Agriculture for any accident which involves serious injury or illness or death to an individual or individuals as a result of the operation of an amusement ride or attraction within 48 hours of the accident. The owner or lessee must retain at all times up-to-date maintenance and inspection records for each amusement ride and amusement attraction in accordance with any regulations the department may prescribe. Such records shall be made available to the department upon reasonable request.

PA **1996 Pa. Laws, Act 113 (HB 1855)** adds to the State Board of Dentistry the power to require, as a condition of renewal of any license or certificate, the maintenance of current certification to administer cardiopulmonary resuscitation (CPR). The board may recognize the maintenance of certification in CPR or basic life support offered by a bona fide charitable organization.

RI **1996 R.I. Pub. Laws, Chap. 143 (HB 7834)** changes the fines for violation of the child passenger restraint law to $150 for each offense. Previously, fines were $30 for the first offense, $60 for the second offense and $100 for every subsequent violation.

SC **1996 S.C. Acts, Act 291 (H 3320)** specifies safety requirements for personal watercraft and requires that an operator under 16 years old must be accompanied by a person at least 18 years old unless he has completed a boating safety program.

TN **1996 Tenn. Pub. Acts, Chap. 747 (H 2366)** requires the Department of Health and Human Services to jointly develop information and instructional materials on shaken baby syndrome for distribution, free of charge, to health care facilities, midwives and child welfare agencies. The information and materials must be provided free of charge by each health care facility to parents or guardians of each newborn, upon discharge from the health care facility. If a home birth is attended by a licensed midwife, the nurse midwife must provide the information and instructional materials to the parents or guardians of the newborn.

TN **1996 Tenn. Pub. Acts, Chap. 1025 (S 2134)** requires the commissioner of health to establish and maintain a central registry of those who sustain traumatic brain injury. The purpose of the registry is to collect information to facilitate the development of injury prevention, treatment and rehabilitation programs and to give people with traumatic brain injury information on public or private agencies that provide rehabilitation services so that injured persons may obtain needed services to alleviate injuries and avoid related secondary problems. The act gives the commissioner the power to collect and analyze injury incidence information and conduct special studies on the causes and consequences of traumatic brain injury.

UT **1996 Utah Laws, Chap. 208 (SB 199)** requires the commissioner of public safety to make rules that establish approved headgear for operators of electric-assisted bicycles. A person operating an electric-assisted bicycle must have a valid driver's license or motorcycle driver's license. Electric-assisted bicycles are exempt from insurance requirements.

WA **1996 Wash. Laws, Chap. 158 (SB 6229)** prohibits used or second-hand cribs that do not meet certain industry and federal safety standards from being placed in the retail market. These provisions do not apply to hotels, motels, day-care centers, or licensed day-care homes until 1999.

WV **1996 W. Va. Acts, Chap. 76 (SB 89)** makes it unlawful for anyone under 15 years of age to operate or be a passenger on a bicycle on a public roadway, bicycle path, or other public right-of-way unless the person wears an approved bicycle helmet of good fit and fastened securely on the head with straps. It is unlawful for a parent or guardian to knowingly permit a child to violate this requirement. The act sets fines and requires the Governor's Highway Safety Program to conduct an educational and public awareness program to encourage people to comply with the act.

WI **1996 Wis. Laws, Act 420 (AB 252)** prohibits anyone from operating on a highway a truck weighing 10,000 pounds or less when a child under the age of 16 years is in the open cargo area of the truck. Exemptions are given for farm operations, parades sanctioned by a local municipality and trucks transporting licensed deer hunters, during the authorized deer hunting season.

INSURANCE

Access to Providers in Managed Care

AL **1996 Ala. Acts, Act 671 (H 625)** creates the Women's Access to Health Care Act, which provides for the inclusion of obstetricians and gynecologists as primary care physicians and prevents a health benefit plan from requiring a referral from a primary care physician as a condition for the coverage of an obstetrician's or gynecologist's services.

CA **1996 Cal. Stats., Chap. 527 (SB 1596)** allows health care plans and health insurers to pay for or reimburse the cost of services provided by pharmacists.

CA **1996 Cal. Stats., Chap. 533 (SB 1798)** permits medical groups and independent practice associations contracting with health plans to contract with licensed nonphysician providers. The act permits the nonphysician providers to bill the health plan directly for services and to be listed in plan directories.

CO **1996 Colo. Sess. Laws, Chap. 153 (HB 1082)** prohibits the issuance or renewal of a managed care plan that provides coverage for reproductive health or gynecological care unless the plan either provides a woman direct access to an obstetrician or gynecologist participating and available under the plan or establishes procedures to ensure that, upon a woman's timely request for a referral to such a physician, the request is not unreasonably withheld.

CT **1996 Conn. Acts, P.A. 96-227 (HB 5364)** extends to subscribers of health care centers, including HMOs, the requirement that women have direct access to network obstetricians or gynecologists for certain services.

FL **1996 Fla. Laws, Chap. 223 (SB 910)** prohibits certain misrepresentations by HMOs on the availability of providers and specifies requirements for HMOs in providing emergency services and care. The act specifies an emergency medical condition with respect to a pregnant woman to mean there is inadequate time to effect safe transfer to another hospital before delivery, a transfer may pose a threat to the health and safety of the patient or fetus, or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

FL **1996 Fla. Laws, Chap. 279 (HB 1239)** prohibits an HMO from discriminating against or failing to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of osteopathic physicians. Nothing in the act mandates that an HMO contract with a hospital.

GA **1996 Ga. Laws, p. 820 (S 592)** allows an insured woman to see an obstetrician or gynecologist who is one of the health plan's network providers without first obtaining a referral, provided that the services are limited to those defined by the Accreditation Council for Graduate Medical Education for training as an OB/GYN, including but not limited to diagnosis, treatment and referral. Each health benefit policy must disclose to its insureds in clear, accurate language, a person's right to direct access to obstetricians and gynecologists at the time of enrollment and at least annually thereafter.

GA **1996 Ga. Laws, p. 821 (H 1404)** requires that if employers offer health benefits to eligible employees or individuals only through an HMO, then that HMO must offer or make arrangements for the offering of a point-of-service option that eligible employees may accept or reject. An employer may require an employee who accepts the point-of-service option to pay the portion of the premium over the amount for the coverage offered by the HMO.

IL **1996 Ill. Laws, P.A. 89-373 (SB 1246)** requires health or accident insurers and managed care plans that require an insured to designate a gatekeeper to coordinate care or control access to health care services to also allow female insureds to designate a woman's principal health care provider. This provider must be a licensed physician specializing in obstetrics and gynecology. Insureds designating a woman's principal health care provider must be given direct access to that provider for covered services or treatment without the need for referral or prior approval.

IN **1996 Ind. Acts, P.L. 192 (SB 392)** provides that a health insurance policy may not require an insured to seek a referral from a primary care provider in order to obtain services related to women's health from certain providers. An insurer also may not prohibit a provider who primarily provides women's health services from serving as a primary care provider if the provider meets certain standards and requests designation as a primary care provider.

IN **1996 Ind. Acts, P.L. 195 (SB 378)** amends the definition of "participating provider" in the law on health maintenance organizations to include a subcontractor of a contractor of an HMO. If a participating provider contracts with another provider to provide health care services to enrollees of an HMO, neither provider is required to obtain a certificate of authority as a health maintenance organization.

IN **1996 Ind. Acts, P.L. 331 (SB 191)** requires an insurer that is organizing a preferred provider plan to make available to a provider of health care services, upon request, a written statement of the terms and conditions under which providers may enter into preferred provider agreements with the insurer. If an insurer denies a provider the right to enter into an agreement with the insurer on the grounds that the provider does not satisfy the terms and conditions established by the insurer, the insurer must provide to the provider a written notice that explains the basis of the insurer's denial.

KY **1996 Ky. Acts, Chap. 187 (HB 782)** requires health insurance policies to guarantee that covered people will have direct access to the primary chiropractic provider of their choice without referral from another provider.

ME **1996 Maine Laws, Chap. 617 (LD 1385)** requires all health plans to cover pap tests recommended by a physician, with a few exceptions for limited coverage plans. A managed care plan must permit a physician who specialized in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the organization's credentialing policy. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner, or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. If the examination reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner, or certified nurse midwife to secure from the patient's primary care physician a referral to the participating provider from whom such care may be obtained. This act does not prohibit a carrier from requiring a participating physician, certified nurse practitioner, or certified nurse midwife to inform a woman's primary care physician before each treatment.

MI **1996 Mich. Pub. Acts, Act 515 (HB 5570)** applies certain provisions of Michigan's "Prudent Purchaser Act" to HMOs (see also Act 518 under "Insurance-Other Consumer Protections"). The act applies to health maintenance organizations that contract with health care providers to become affiliated providers or that offer a prudent purchaser contract. The act allows HMOs to enter into a contract with one or more health care providers to control health care costs, assure appropriate utilization of health maintenance services and maintain quality of health care. The HMO may limit the number of contracts entered into if the number of contracts is sufficient to assure reasonable levels of access to health maintenance services for recipients of those services, subject to approval by the Department of Commerce. However, the HMO must offer a contract comparable to those contracts entered into with other affiliated providers, to at least one health care provider that provides the applicable health maintenance services and is located within a reasonable distance from the recipients of those health maintenance services, if a health care provider that provides the applicable health maintenance services is located within that reasonable distance. An HMO also must give all health care providers that provide the applicable health maintenance services and are located in the geographic area served by the HMO an opportunity to apply to become an affiliated provider. A contract must be based upon written standards that include maintaining quality health care, controlling health care costs, assuring appropriate utilization of health care services and assuring reasonable levels of access to health care services.

The act also requires HMOs to develop and institute procedures that are designed to notify health care providers that provide the applicable health maintenance services and are located in the geographic area served by the organization of the acceptance of applications for a provider panel, including giving notice in a newspaper.

NC **1996 N.C. Sess. Laws, Chap. 713 (SB 855)** authorizes public hospitals to acquire an ownership interest in a managed care company with which the public hospital is also directly or indirectly a contracting provider. The act also makes confidential any financial information related to the provision of health care between a hospital and a managed care organization, insurance company, employer, or other payer. This provision expires June 1, 1997.

TN **1996 Tenn. Pub. Acts, Chap. 627 (H 1335)** adds registered nurses to the category of health care professionals who are eligible for reimbursement under insurance contracts, plans and policies issued or renewed on or after July 1, 1995.

UT **1996 Utah Laws, Chap. 38 (SB 23)** limits an insurer's ability to deny coverage for failure to obtain preauthorization for maternity care.

UT **1996 Utah Laws, Chap. 339 (HB 146)** permits an insured person to choose a health care provider or facility when the insurer's provider or facility is not within 30 miles. The act requires the insurer to reimburse the insured's health care provider or facility on the same terms as the insurer reimburses its providers and facilities. The act limits the liability of an insurer for acts or omissions of a provider or facility chosen by an insured. The act also clarifies referral procedures and allows providers and facilities in counties of less than 30,000 people to contract with an insurer on the same terms and conditions as providers or facilities under contract with or employed by the insurer. Finally, the act requires the Health Policy Commission to study issues related to managed health care in rural and frontier Utah and report its findings to the Health and Environment Interim Committee before November 1, 1996.

VA **1996 Va. Acts, Chap. 967 (HB 442)** requires health insurers (including HMOs), providing obstetrical and gynecological services under their policies or plans, to permit females (age 13 and older) to have direct access to obstetrical-gynecological services, without the necessity of prior referral, if the provider is authorized to provide services under the policy and the provider is selected by the woman. The participating obstetrician-gynecologist may be required by the health insurer to notify, in writing, the primary care provider of any self-referred visit and to include in this notice a description of the rendered services. The services covered by this exception from prior authorization include an annual wellness examination and routine health care services incident to and rendered during an annual visit. Additional services may be provided if there is consultation between the primary care physician (PCP) for follow-up care or subsequent visits; prior consultation and authorization by the PCP, including a visit to the PCP, if determined necessary by the PCP, before the patient may be directed to another specialty provider; and prior authorization by the insurer, etc. , for proposed inpatient hospitalization or outpatient surgical procedures. The term "health care services" is defined to include the recommendations of the American College of

Obstetricians and Gynecologists and the services of nurse practitioners, physician's assistants and certified nurse midwives in collaboration with the obstetrician-gynecologists. Notice of these requirements must be given. These requirements will apply any time there is a delivery, reissuance, renewal, extension of when the terms of any policy are changed or the premium adjusted.

WA **1996 Wash. Laws, Chap. 312 (SB 6392)** requires health carriers to disclose, upon request by a patient or the Washington Health Care Authority, the availability of a point-of-service plan and how the plan operates within the coverage, any documents or other information referred to in the enrollment agreement and a full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and who must authorize the referral.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** amends the definition of health care services to include chiropractic services and pediatric services. The definition of primary care physician is amended to allow a certified nurse-midwife to be chosen in lieu of a subscriber's primary care physician during the subscriber's pregnancy and for a period extending through the end of the month in which the 60-day period following termination of pregnancy occurs

Gag Clauses

CA **1996 Cal. Stats., Chap. 260 (SB 1847)** prohibits anyone from penalizing a physician for advocating on behalf of a patient, or discouraging a physician from communicating information to a patient that furthers medically appropriate health care.

CA **1996 Cal. Stats., Chap. 1089 (AB 3013)** prohibits health care service plans from contractually limiting a physician or other licensed health care provider from fully advising patients about treatment options.

CA **1996 Cal. Stats., Chap. 1094 (SB 1805)** makes violations of existing law protecting health care practitioners, physicians, or surgeons who advocate for appropriate health care on a patient's behalf subject to the criminal sentences provided by the Knox-Keene Health Care Service Plan Act of 1975.

CO **1996 Colo. Sess. Laws, Chap. 122 (HB 1216)** requires that a contract between an insurance carrier and a health care provider concerning delivery of health care services covered by a managed care plan contain provisions stating that a carrier and a provider cannot be prohibited from disagreeing with a medical decision, medical policy, or medical practice of the other; that a carrier is prohibited from terminating a contract with a provider because the provider disagrees with a carrier's decision to deny or limit an insured's benefits or because the provider assists the insured to protest such decision; and that a carrier is prohibited from terminating a contract with a provider because the provider discusses with a current, former, or prospective patient, such patient's medical condition and proposed treatment whether or not such treatment is covered by the plan, policy provisions of the plan, or a provider's personal recommendation regarding selection of a plan. The law allows language in a contract that prohibits the provider from making or circulating any statement that is false or maliciously critical of the carrier and calculated to injure the carrier.

DE **Vol. 70 Del. Laws, Chap. 537 (SB 449)** prohibits insurance companies and health maintenance organizations (HMOs) from utilizing non-disclosure or "gag" clauses. The act prohibits insurers from refusing to contract with or compensate an eligible health care provider for communication to patients regarding provisions of the insurer's contract.

GA **1996 Ga. Laws, p. 751 (H 1338)** directs that plans are forbidden from penalizing a physician or health care provider for discussing medically necessary or appropriate health care.

IN **1996 Ind. Acts, P.L. 192 (SB 392)** provides that an agreement between an insurer or a health maintenance organization and a health care provider may not prohibit the disclosure of certain financial or treatment information.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** prohibits managed care plans from terminating, refusing to contract with, or otherwise disciplining providers participating in the plan when the provider advocates for medically appropriate care for plan enrollees. The act requires health plans to provide prospective and current enrollees and providers specified information about the terms and conditions of the plan to enable those people to make informed decisions regarding their choice of plans. In addition to information about services covered, services not covered, copayments and deductibles, restrictions on particular provider types, how the plan addresses the provision of appropriate and accessible care in a timely fashion and other details, the plans must provide information about procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or formulary, if any.

MD **1996 Md. Laws, Chap. 548 (HB 1374)** protects health care providers in communications with patients about treatment options or coverage by prohibiting gag rules.

MA **1996 Mass. Acts, Chap. 8 (HB 5347)** prohibits the use of "gag clauses" by insurers in their contracts with providers. The act prohibits an insurer from refusing to contract with or compensate an otherwise eligible provider or non-participating provider solely because the provider has, in good faith, communicated with one or more of his current, former, or prospective patients regarding the insurer's products as they relate to the patient's needs. The act also requires, in cases pertaining to mental health treatment, that insurers obtain written, informed consent before disclosing information other than the patient's name, diagnosis, date and type of service.

NH **1996 N.H. Laws, Chap. 149 (HB 1459)** prohibits contracts between health care insurers and health care providers from limiting what information such health care providers may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of the health care insurer's products as they relate to the needs of such provider's patients except for trade secrets of significant competitive value.

NY **1996 N.Y. Laws, Chap. 705 (S 7553)** bans limitations imposed by HMOs or insurers on a health care provider's right to advocate to the HMO or insurer on behalf of the patient (so-called "gag orders").

PA **1996 Pa. Laws, Act 85 (HB 1977)** prohibits the insurer from refusing to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because the provider has in good faith communicated with patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of the provider's patients.

RI **1996 R.I. Pub. Laws, Chap. 41 (HB 8172)** makes it unlawful for a health plan to refuse to contract with or compensate an otherwise eligible provider or non-participating provider for covered services solely because that provider has in good faith communicated with his or her patients regarding the provisions, terms, or requirements of the insurer's products as they relate to the needs of that provider's patients.

TN **1996 Tenn. Pub. Acts, Chap. 874 (H 2077)** establishes the Patients' Right to Truth Act of 1996 which prohibits managed care organizations from restricting what medical personnel can tell patients about alternative medical care, treatments, programs, or pharmaceuticals which may be available to the patient regardless of whether covered by the plan or not. A violation is punishable by payment of a civil penalty of not more than $1,000 unless the person knew or reasonably should have known such person was in violation, in which case the penalty is not more than $5,000 for each violation, but not to exceed an aggregate penalty of $50,000 in any six-month period.

VA **1996 Va. Acts, Chap. 776 (HB 1393)** provides that contracts between a carrier and provider must permit and require the provider to discuss medical treatment options with the patient.

WA **1996 Wash. Laws, Chap. 312 (SB 6392)** prevents health carriers from prohibiting or "gagging" providers from informing patients of the care they require or stopping an enrollee from freely contracting for any health care service outside the carrier's health care plan.

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General

AK **1996 Alaska Sess. Laws, Chap. 16 (HB 226)** permits employers to provide employees who have a spouse or dependent child with greater health and retirement benefits than the employer provides to employees without a spouse or dependent children. The act also permits labor organizations to negotiate with employers for greater health and retirement benefits for employees who have a spouse or dependent children.

CA **1996 Cal. Stats., Chap. 864 (SB 1665)** enacts the Telemedicine Development Act of 1996, setting standards for the use of telemedicine by health care practitioners and insurers. The act prohibits health insurers from requiring face-to-face contact between a health care provider and patient for services appropriately provided through telemedicine, subject to the terms of the contract.

CO **1996 Colo. Sess. Laws, Chap. 241 (HB 1208)** enacts a procedure that applies to a child support obligor who provides health insurance coverage for a child pursuant to a court order through an insurance provider other than one available to the obligee through his or her employment. The law requires the obligee, the obligee's representative, or the delegate child support enforcement unit to send written notice by first-class mail to the insurance provider identifying that the obligor is under a court order to provide health insurance coverage for the child. The law specifies that the notice must inform the insurance provider that it is required to notify the obligee, the obligee's representative, or the delegate child support enforcement unit of any cancellation in the coverage.

DE **Vol. 70 Del. Laws, H. Res. 94** requests the secretary of the Department of Health and Social Services, after consultation with the Insurance Commissioner, professional organizations, health insurance providers and consumers and others, to report to the General Assembly concerning regulatory oversight of health insurance providers.

DC **1996 D.C. Stats., Act 11-172 (Bill No. 11-44)** requires the use of a uniform health insurance claim form for physicians, hospitals and other health care providers, which must be accepted by all health insurance carriers.

DC **1996 D.C. Stats., Act 11-234 (Bill No. 11-390)** provides a means for any insurer organized under the laws of any other state to become a domestic insurer in the District of Columbia. The act also provides a means for any domestic insurer to transfer its domicile to another state. Finally, the act provides a means for the continuation of a certificate of authority and other approvals pertaining to any foreign insurer which transfers its corporate domicile to another state by merger or consolidation or any other lawful method.

DC **1996 D.C. Stats., Act 11-524 (Bill No. 11-415)** establishes the Department of Insurance and Securities Regulation as a cabinet level agency of District of Columbia government and transfers to it all functions associated with the regulation of insurance, securities and banking and financial institutions from, respectively, the Department of Consumer and Regulatory Affairs and the Public Service Commission.

GU **1996 Guam Laws, P.L. 23-76** funds the Catastrophic Illness Assistance Program within the FY 96 budget of the Department of Public Health, increases the benefit cap from $100,000 to $175,000 and requires the adoption of rules and regulations in accordance with the Administrative Adjudication Law to administer the program.

ID **1996 Idaho Sess. Laws, Chap. 53 (HB 413)** prevents an employer from disenrolling a child from health insurance coverage when the coverage has been required by a court or administrative order, unless the employer has been provided satisfactory written evidence that the court order is no longer in effect, the child is enrolled in other comparable health care coverage, the employer has eliminated family health coverage for all of its employees, or the employee upon whose employment the health coverage is premised has ceased employment with the employer and reasonable measures have been taken to give notice to the parents or guardians of the child.

ID **1996 Idaho Sess. Laws, Chap. 96 (HB 449)** adopts the "Risk-Based Capital for Insurers" model act.

ID **1996 Idaho Sess. Laws, Sen. Concur. Res. 136** authorizes the Legislative Council to appoint an interim committee to study managed health care and associated health care organizations and finance issues.

IN **1996 Ind. Acts, P.L. 186 (SB 356)** requires each domestic life and health insurer to annually calculate and report to the insurance commissioner several figures representing the risk-based capital (RBC) levels of the insurer. The RBC levels are to be calculated according to certain instructions adopted by the National Association of Insurance Commissioners (NAIC).

IN **1996 Ind. Acts, P.L. 251 (HB 1289)** changes the name of the Preferred Provider Plan Study Committee (which was established by P.L. 134-1994) to the Managed Care Study Committee and requires the committee to study all aspects of managed care, including economic incentives that exist under capitated managed care health plans, the impact of managed care on patient satisfaction, standards and criteria used in the selection of health care providers and the impact of managed care on access to specialty care.

IA **1996 Iowa Acts, Chap. 1169 (HF 2144)** requires third-party payers to include in the policies or contracts for third-party payment or prepayment of health and medical expenses a provision for payment of services provided by a licensed physician assistant or advanced registered nurse practitioner if payment for such services would be included for those engaged in the practice of medicine and surgery or in the practice of osteopathic medicine and surgery. The requirement applies to contracts or policies delivered, issued for delivery, continued or renewed on or after July 1, 1996, or an existing policy or contract on the anniversary or renewal date of the policy or contract, or upon expiration of an applicable collective bargaining agreement. The act exempts managed care organizations unless the practitioner's collaborating physician has entered into a contract with that entity.

KY **1996 Ky. Acts, Chap. 348 (SB 400)** requires insurers offering medical professional liability insurance to make available the same coverage for charitable health care providers that it offers to non-charitable health care providers.

KY **1996 Ky. Acts, Chap. 365 (HB 300)** adds medical support, maintenance and medical support insurance to the factors considered when wage withholdings for child support may occur; and requires the cabinet to combine any administrative or judicial wage withholding order or multiple administrative or judicial orders, for child support and medical support into a single wage withholding order when payable through the cabinet to a single family or to multiple family units.

KY **1996 Ky. Acts, Chap. 371 (SB 343)** makes numerous changes to the comprehensive health reform legislation enacted in 1994. The act abolishes the Health Policy Board and transfers its duties to various state agencies. The health data collection is transferred to Cabinet for Human Resources; the health insurance responsibilities are transferred to the Department of Insurance; the 24-hour coverage pilot is transferred to the Department of Insurance; and the certificate of need functions are transferred to the Cabinet for Human Resources.

Relating to the Health Purchasing Alliance, the act specifies that alliances are to be attached for administrative purposes to the Department of Insurance but operated independently. The act also exempts use of modified community rating issued to an association that: existed before January 1, 1996; meets a statutory definition; does not deny membership on basis of health status or claims; and complies with portability, renewability, guaranteed issue and preexisting exclusion provisions. The act also permits phase in of modified community rating.

The act creates a seven-member Health Insurance Advisory Council to advise the insurance commissioner on issues that impact the provision of health insurance. It also makes several changes to insurance law including directs in the commissioner to hold a hearing on every filing that contains an average rate increase that exceeds the medical price index plus 10 percent; prohibiting insurers receiving approval from submitting a new rate or fee increase for the same policies/contracts within 12 months; and permitting continuation of group coverage for 18 months rather than nine after a person terminates group membership. The act increases the preexisting exclusion from six to 12 months and maintains modified community rating, but permits use of: gender (no more than a 50 percent variation from lowest to highest factor; occupation/industry (no more than a 15 percent variation); and for all case characteristics (no more than a 5:1 variation from highest to lowest rate factor). The act allows for a 10 percent discount for healthy lifestyles.

The act also permits creation of provider sponsored networks and requires the networks to obtain a certificate of filing from the commissioner of insurance.

LA **1996 La. Acts, H. Concur. Res. 28** creates the Louisiana Study Commission on Parity and Nondiscrimination in Health Care for Serious Mental Illnesses to study the feasibility of legislation to prohibit discrimination in health insurance policies for those with severe mental disorders.

LA **1996 La. Acts, P.A. 71 (SB 180)** requires each application for a certificate of authority to do business as an HMO in the state to be verified by an officer or authorized representative of the applicant and include biographical background information, on a form prescribed by the commissioner, for all responsible parties including all members of the board of directors, the principal officers and each shareholder with over ten percent interest.

MD **1996 Md. Laws, Chap. 425 (HB 10)** repeals existing loss and ratio guidelines by which the insurance commissioner may require new rate filings on a health benefit plan offered by a nonprofit health service plan, insurer, or HMO and establishes new guidelines. A loss and ratio of a health benefit plan, expressed as a percentage, is the portion of the premiums returned to policy holders in the form of health benefits. The act establishes a loss and ratio benchmark of 60 percent in the individual market. The act authorizes the commissioner to require new rate filings for health benefit plans in the individual market that do not meet the benchmark.

The act also revises reporting requirements for health carriers to require reporting by line of business instead of aggregate reporting. All health benefit plans must supply data annually on a variety of items including premiums, claims and expenses. The act directs the commissioner of insurance to forward, by May 1, any information needed by the Health Care Access and Cost Containment Commission for its evaluation of benefits and cost sharing arrangements in the comprehensive standard benefit plan.

MA **1996 Mass. Acts, Chap. 297 (HB 6231)** extends the definition of a small group to businesses with 50 employees or fewer, from 25 or fewer and prohibits insurers from varying premium rates based on sex or gender in any health plan issued or renewed on or after August 15, 1996. The act allows for a phase-out of excessive premium rate charges for carriers insuring groups that have between 26 and 50 members and specifies times and rates to accomplish this.

MS **1996 Miss. Laws, Chap. 342 and 463 (HB 1276 and HB 1421)** amend current law to authorize the regional mental health/mental retardation commissions to enter into managed care contracts to provide facilities and services on a discounted or capitated basis and to establish or operate a managed care entity. In addition, HB 1421 requires the regional centers to provide services to children.

NH **1996 N.H. Laws, Chap. 134 (HB 1613)** prohibits and eliminates exclusivity contracts between health care insurers and health care providers.

NM **1996 N.M. Laws, H. Jt. Mem. 20** requests that the New Mexico Health Policy Commission, in cooperation with the Department of Health, the Human Services Department and the Department of Insurance, study and propose options to improve access to comprehensive health care by better use of existing public and private funds. The study is to include current federal, state and local fiscal resources and how they can be realigned to improve health care purchasing and delivery; publicly funded insurance programs and how restructuring can improve quality and access to insurance; roles and responsibilities of the private sector and state and local governments; processes to involve the public, advocates and providers in health care spending and benefit decisions; and how private health care dollars can be leveraged with public dollars to provide more services to the uninsured.

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which continues only until December 31, 1996, existing provisions of the state's hospital reimbursement rate-setting law. The acts continue beyond 1996 until December 31, 1999, the same rate-setting methodology only for Medicaid and certain other payers. The acts deregulate the payment system for most other payers, on and after January 1, 1997, by allowing them to negotiate with hospitals to establish their own payment rates.

The acts establish a number of new provisions for the financing of "public goods programs" on and after January 1, 1997. Insurers and other payers must pay allowances on payments for services rendered, as well as per-person payments for each individual or family member covered by the insurer ("covered lives assessments"), which go into a pool to fund the public goods programs. Funds from these payments, as well as certain Medicaid funds and other payments, are used to finance the costs of graduate medical education, various insurance programs for the uninsured, primary care development, emergency medical services training and health facility restructuring and provider networking programs designed to assist providers in adapting to the changing health care environment.

For example, the acts authorize the commissioner of health to distribute funds in the health care initiatives pool for the Child Health Plus Program ($120 million in 1997, $164 million in 1998 and $181 million in 1999), the Small Business Health Insurance Partnership Program, the Voucher Insurance Program, the Individual Subsidy Program, the Catastrophic Health Care Expense Program, the Primary Health Care Services Pool and the Primary Care Education and Training Program (including the loans, scholarships and medical education grants for minority participation).

The acts create a new State Task Force on Health Care Quality Improvement and Information Systems within the Department of Health and authorize the commissioner of health to award grants to support collaborative community-based efforts to improve health status and quality of care.

The acts make permanent the Child Health Plus Program, through which primary and preventive health services are provided to eligible children, expand the program by increasing the age limit for eligibility, add coverage for hospital and related inpatient services and make several other changes. Participating insurers must impose a copayment of $2 per visit for physician services, in addition to the other copayments and coinsurances for which insurers are permitted to require payment.

The acts increase the required family contribution toward the premium costs for children's coverage, concurrently with the addition of inpatient services on January 1, 1997, to make such payments vary based on the relationship of the family's net income to the non-farm federal poverty level (FPL), as follows: for income less than the FPL, no payments; for income 100 percent to 132 percent of FPL, payments of $9 monthly per eligible child (with a maximum per family of $36 monthly); and for income 133 percent to 185 percent of FPL, $13 monthly per eligible child (family maximum $52 monthly).

The acts establish a new program entitled the "New York State Small Business Health Insurance Partnership Program," administered by DOH, to assist eligible employers in purchasing small group health insurance or comprehensive health services plan coverage for employees and their dependents. The program applies to employers of less than 50 full-time employees (those who work at least 20 hours per week), which have not provided group health insurance benefits to any employees for the past 12 months.

The acts authorize the superintendent of insurance, in conjunction with the commissioner of health, to conduct a demonstration program to assist eligible individuals and families in purchasing health care coverage from approved insurers and make this program available to individuals and families who can adequately document that: they reside in specific areas designated by the superintendent;

their gross household family income does not exceed 122 percent of the non-farm federal poverty level; and they are not eligible for Medicaid or Medicare, do not have equivalent health care coverage and have not had equivalent coverage within the 12-month period before application, with exceptions. Vouchers may be provided to such individuals and families and the vouchers may then be submitted to participating insurers in order to obtain coverage.

The acts allow Rural Health Network Development Grants to be used to support activities and organizational costs, including the recruitment of qualified health care professionals, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community-based primary care systems and the integration and expansion of prehospital emergency medical services. The acts create a new "Rural Health Care Access Development Program," through which grants and financial assistance can be provided to general hospitals classified as rural hospitals under federal or state regulations, in recognition of the unique costs incurred by these facilities in providing hospital services in remote or sparsely populated areas.

The acts require each hospital's performance in meeting the health care needs of the community, providing charity care services and improving access to health care services by the underserved.

NC **1996 N.C. Sess. Laws, Chap. 713 (SB 855)** authorizes public hospitals to acquire an ownership interest in a managed care company with which the public hospital is also directly or indirectly a contracting provider. The act also makes confidential any financial information related to the provision of health care between a hospital and a managed care organization, insurance company, employer, or other payer. This provision expires June 1, 1997.

OK **1996 Okla. Sess. Laws, Chap. 335 (SB 1166)** prohibits hospitals and other providers from charging patients the difference between the discounted rate paid by managed care plans and the full cost of the services provided. The measure also requires insurers and health plans to disclose the calculations on which a copayment is based and to base the copayment on either the amount charged to the insurer or the amount actually paid by the insurer, whichever is less.

PA **1996 Pa. Laws, Act 159 (SB 1110)** enacts the Accident and Health Filing Reform Act, which requires insurance plans to file certain forms with the Insurance Department, including rates for both group and individual accident and health insurance policies which it proposes to use. The act requires each hospital plan corporation, professional health services plan corporation and HMO to establish a base rate which is not excessive, inadequate or unfairly discriminatory. The initial base rate is the rate or the rating formula currently on file and approved by the department as of the effective date of the act. Proposed changes to an approved base rate or any approved component of an approved rating formula which effect an increase or decrease of more than 10 percent annually in the aggregate shall be subject to filing, review and prior approval by the department, with a few exceptions. Pending a hearing, the insurance commissioner may order the suspension of use of a rate filed and reinstate the last previous rate in effect if the commissioner has reasonable cause to believe that the rate is excessive, inadequate or unfairly discriminatory; unless a suspension order is issued, insureds will suffer substantial harm; the harm insureds will suffer outweighs any hardship the insurer will suffer by the suspension of the use of the form; and the suspension order will result in no harm to the public.

SD **1996 S.D. Sess. Laws, Chap. 297 (HB 1059)** requires the registration of utilization review organizations. The registration is to be in a format prescribed by the director of the Division of Insurance. In prescribing the form or in carrying out other functions required by the act, the director will consult with the secretary of the Department of Health, if applicable. The director or the secretary of health may require that the following information be submitted: (1) information relating to its actual or anticipated activities in this state; (2) the status of any accreditation designation it holds or has sought; (3) information pertaining to its place of business, officers and directors; (4) qualifications of review staff; and (5) any other information reasonable and necessary to monitor its activities in the state.

TN **1996 Tenn. Pub. Acts, Chap. 627 (H 1335)** adds registered nurses to the category of health care professionals who are eligible for reimbursement under insurance contracts, plans and policies issued or renewed on or after July 1, 1995.

UT **1996 Utah Laws, Chap. 276 (HB 404)** provides a tax deduction of 60 percent of the amounts paid by the taxpayer during the taxable year for health care insurance for the taxpayer and his or her spouse and dependents to the extent the amounts paid for health insurance were not deductible under the federal Internal Revenue Code. The act clarifies that a deduction is not allowed for amounts that are reimbursed or funded in whole or in part by government and for a taxpayer who is eligible to participate in a health plan that is funded in whole or in part by the taxpayer's employer. The deduction is allowed for tax years beginning on or after January 1, 1996.

UT **1996 Utah Laws, Chap. 339 (HB 146)** permits an insured person to choose a health care provider or facility when the insurer's provider or facility is not within 30 miles. The act requires the insurer to reimburse the insured's health care provider or facility on the same terms as the insurer reimburses its providers and facilities. The act limits the liability of an insurer for acts or omissions of a provider or facility chosen by an insured. The act also clarifies referral procedures and allows providers and facilities in counties of less than 30,000 people to contract with an insurer on the same terms and conditions as providers or facilities under contract with or employed by the insurer. Finally, the act requires the Health Policy Commission to study issues related to managed health care in rural and frontier Utah and report its findings to the Health and Environment Interim Committee before November 1, 1996.

WA **1996 Wash. Laws, Chap. 304 (SB 6129)** requires that health carriers not write contracts that deny enrollees and mental health practitioners the option of independently arranging to continue care, at the enrollee's expense, after the benefits of the contract expire. If a consumer continues to see a mental health practitioner during an appeal process, the provider must indicate in writing who will be responsible for payment of services during this period.

WV **1996 W. Va. Acts, Chap. 152 (HB 4207)** creates the West Virginia Health Maintenance Organization Guaranty Association. All HMOs must be members of the association in order to retain their certificates of authority. After notification by the commissioner of insurance that an HMO is insolvent, the association must appoint one or more HMOs in the given service area to enroll the covered individuals within that service area. If no HMO is operating within a given service area, the act requires the association to enroll covered individuals in the HMO it deems best suited. The terms of the contract must be comparable to those which were extended to the covered individuals by the insolvent HMO. A preexisting condition which has not been excluded under the covered individual's policy with the insolvent HMO cannot be excluded by the HMO appointed by the association.

WI **1996 Wis. Laws, Act 442 (AB 1034)** creates the Council on Health Care Fraud and Abuse, attached to the Department of Administration. The council consists of 15 members, including someone with expertise in the medical assistance program, as well as representatives of insurers, employee benefit plan administrators, HMOs, physicians, other health care providers and law enforcement. The council will develop strategies to combat health care fraud and abuse by consumers, providers and insurers; examine problems that relate to electronic claims for payment; survey efforts of other states to reduce fraud and abuse; conduct public hearings; and engage in public information programs concerning health care fraud and abuse. The act requires the council to report annually to the governor and the Legislature. The report must identify different types of fraud and abuse in health care, analyze related issues such as self-interested referrals, list successful prosecutions of health care fraud that have been conducted in the state courts in the state, specify activities conducted by the council to combat the problem and recommend specific proposed changes to state statutes or administrative rules. The council terminates on December 30, 2000.

Health Insurance Purchasing

CA **1996 Cal. Stats., Chap. 916 (SB 1559)** enacts the Private Health Care Voluntary Purchasing Alliance Act and establishes a structure under which the insurance commissioner would regulate the alliances.

CO **1996 Colo. Sess. Laws, Chap. 136 (HB 1264)** adds definitions to the statutes governing health care coverage cooperatives to make such provisions consistent with the laws regulating small group health insurance, clarifies the type of bond a cooperative must post in order to obtain a certificate of authority, specifies requirements for cooperatives to obtain carrier waiver certificates from the executive director of the Department of Health Care Policy and Financing and allows health insurance entities offering coverage through a waivered health care coverage cooperative to offer certain standardized coverages and specially negotiate rates only to cooperative members and not to others outside the cooperative.

IL **1996 Ill. Laws, P.A. 89-486 (HB 3186)** changes the Comprehensive Health Insurance Plan (CHIP) to restrict "optional family coverage" to members of the household of a person insured by CHIP only if they meet the criteria for regular eligibility. (Previous law made all members eligible for CHIP if one member qualified.) Rates for optional family coverage and deductible and coinsurance amounts, are to be set by the CHIP board. People buying waivers of the preexisting conditions exclusion need pay the required surcharge of up to 10 percent for only 60 months instead of indefinitely.

IL **1996 Ill. Laws, P.A. 89-628 (HB 3520)** allows the comprehensive Health Insurance Plan (CHIP) to discount or subsidize premiums for elderly, retired, or unemployed participants if funds allow.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** creates the Maine Health Care Reform Act of 1996, which institutes health plan improvements and provides for the creation of private purchasing alliances. The act creates a licensing and regulatory process to allow the establishment of private purchasing alliances in Part A. Private purchasing alliances are nonprofit corporations licensed by the Bureau of Insurance to provide health insurance to members through multiple unaffiliated participating carriers. When established, an alliance must offer a range of health plans from at least three different carriers within the alliance's service area. One of these health plans must be a catastrophic plan providing coverage for inpatient hospital benefits only.

UT **1996 Utah Laws, Chap. 143 (HB 273)** provides for the establishment of voluntary health purchasing alliances or cooperatives. An alliance is a nonrisk-bearing, nonprofit corporation or trust that makes health insurance available to its members from multiple unaffiliated insurers. The act directs the commissioner of insurance to facilitate the creation and operation of alliances and establishes their powers and duties, including creation of boards, marketing standards, collection of premiums, enrollment procedures and reporting.

Individual and Small Group Reform

AK **1996 Alaska Sess. Laws, Chap. 15 (SB 178)** increases the number of eligible employees that constitute an employer group for purposes of small employer health insurance and changes the definition of "small employer."

CA **1996 Cal. Stats., Chap. 50 (SB 849)** clarifies the schedule for phasing in the small group health insurance risk adjustments rating factor and requires that small employer health insurance premium rate bands, which became effective under current law on July 1, 1996, be applied to all in-force business at the time of policy renewal or July 1, 1997, whichever comes first. The act requires the California Major Risk Medical Insurance Board to provide coverage through participating health plans and permits the board to contract for the processing of applications, the enrollment of subscribers and administration activities.

CA **1996 Cal. Stats., Chap. 359 and 360 (AB 8 and SB 371)** extend California's small employer health insurance reforms, which currently apply to groups with three to 50 employees, to groups of two to 50.

CO **1996 Colo. Sess. Laws, Chap. 102 (SB 184)** includes nonprofit corporations and household employees within the definition of "business group of one" for health insurance coverage purposes.

CO **1996 Colo. Sess. Laws, Chap. 113 (HB 1232)** requires health insurers to renew individual health benefit plans except for specified reasons. If the insurer nonrenews all those in the state covered by the same plan, the law states that the insurer cannot accept any individual health insurance business in Colorado for five years. The law makes any failure to comply with these provisions an unfair trade practice under existing statutes.

CT **1996 Conn. Acts, P.A. 96-234 (HB 5645)** allows municipal employees and county sheriff departments to participate in the state employee health insurance plans. The comptroller must submit to the General Assembly, by February 1, 1997, a proposal to offer health insurance plans to small businesses and self-employed individuals, effective January 1, 1998. Any group or individual who elects to participate in the plan must pay the full cost of coverage. Effective October 1, 1996, any employee of the county sheriff's department may participate in the plan on a voluntary basis, with the participant paying the full cost of the coverage.

DE **Vol. 70 Del. Laws, Chap. 104 (HB 240)** clarifies portions of the Small Employer Insurance Reform Act passed by the General Assembly in 1990 at the recommendation of the Delaware Health Care Commission and amended in 1994. It is intended to preclude companies from taking actions designed to escape the force of the act by allowing the commissioner of insurance to identify groups which form for the sole purpose of escaping the reforms and prohibit them from offering non-reformed products to Delaware small businesses. The act is a companion to the act requiring out-of-state associations to file certificates with the Insurance Department before offering products for sale in Delaware.

FL **1996 Fla. Laws, Chap. 319 (SB 14)** extends provisions under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to employers with fewer than 20 employees. The act also establishes the Florida Health Insurance Coverage Continuation Act which provides for continuation coverage for 18 months from the qualifying event, with the employee or dependent paying 115 percent of the applicable premium. The employer does not pay any of the cost for the continuation of coverage. The carrier is responsible for one mailing per household of any required document. The employee must elect coverage and pay the premium within 30 days of receiving the election form and premium notice from the carrier. The carrier can contract with the employer to perform the administrative duties of this act and the employer can, with the carrier's approval, delegate those duties to an entity.

ID **1996 Idaho Sess. Laws, Chap. 124 (SB 1383)** adds to existing law to provide for a conversion plan (which allows an individual to continue insurance when he/she leaves a group plan) for large and small group health insurance carriers that do not offer individual coverage.

IN **1996 Ind. Acts, P.L. 190 (SB 117)** defines types of insurance policies that qualify and do not qualify as individual policies of accident and sickness insurance for purposes of applying preexisting condition exclusions to the transfer of insurance policies. The act provides that an individual who applies for an individual policy of accident and sickness insurance within 30 days after coverage under a small group health insurance policy or another individual policy of accident and sickness insurance expires is entitled to receive credit for time saved under a preexisting condition clause in the expired policy. The act also provides that the period for determining if an employer meets the definition of small employer for purposes of small employer group health insurance is the previous calendar year. Each small employer insurer must annually submit to the Department of Insurance a copy of the actuarial certification the insurer is required to maintain. Portability provisions that apply to an employee of a small employer also apply to the employee's dependents.

IN **1996 Ind. Acts, P.L. 193 (SB 118)** establishes a voluntary reinsurance program for small employer health insurance plans and establishes the Indiana small employer health reinsurance board to supervise and control the program of reinsurance. The board must establish a formula to impose assessments against participating members which may not exceed one percent of the member's total net premiums annually. The act exempts the reinsurance program from all taxes imposed by the state.

KS **1996 Kan. Sess. Laws, Chap. 182 (SB 529)** amends group accident and health insurance statutes, including small group statutes, to allow an individual to enroll in a group outside the open enrollment period if the person had been eligible for, but declined coverage because the person was covered under another group, the person lost coverage due to termination of employment, death of a spouse, or divorce and the person sought enrollment in the eligible group within 31 days of the loss of coverage. No individual would be considered a late enrollee if the court ordered coverage for a spouse or minor child under a covered individual's policy.

MD **1996 Md. Laws, Chap. 288 (HB 957)** eliminates the last step in the phase-in toward community rating for small insurance groups. The act provides that small group carriers may charge rates 33 percent above or below the community rate for health benefit plans issued, delivered, or renewed after July 1, 1996. Currently this rate applies to plans issued, delivered or renewed between July 1, 1996 and June 30, 1997. The act deletes a provision authorizing small group carriers to charge a rate 16 percent above or below the community rate for all health benefit plans issued, delivered, or renewed after July 1, 1997. The act also requires the insurance commissioner, in conjunction with the Health Care Access and Cost Commission, to submit a report to the governor on or before October 1, 2000 (instead of 1998) on the feasibility and desirability of allowing carriers to charge rates that are less than 33 percent above or below the community rate for health benefit plans.

MI **1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573/HB 5571/SB 1166)** require HMOs, insurers and health care corporations to comply with guaranteed renewal requirements for both individual and group policies which means they must renew or continue in force the contract at the option of the individual or group with exceptions, such as fraud or nonpayment.

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** establish a new program entitled the "New York State Small Business Health Insurance Partnership Program," administered by the Department of Health, to assist eligible employers in purchasing small group health insurance or comprehensive health services plan coverage for employees and their dependents. The program applies to employers of less than 50 full-time employees (those who work at least 20 hours per week), which have not provided group health insurance benefits to any employees for the past 12 months.

NC **1996 N.C. Sess. Laws, Chap. 669 (HB 1202)** amends the law governing small employer health benefit plans to make it conform with 1995 legislation and clarifies the applicability of certain medical underwriting provisions. The act gives people who work for small employers credit for previous periods during which they had preexisting medical conditions and were excluded from health insurance coverage.

SD **1996 S.D. Sess. Laws, Chap. 298 (S 32)** deletes a provision that exempted individual health insurance policies from the current small employer insurance requirements.

TN **1996 Tenn. Pub. Acts, Chap. 1040 (S 2459)** adds three representatives from the health care professions who are licensed to practice medicine in the state to the list of people the commissioner of commerce and insurance can appoint to the small employer carrier committee. The act requires this committee to study the feasibility of expanding eligibility for small group employers to include those with more than 25 employees. The committee must report its findings by February 1, 1997.

VA **1996 Va. Acts, Chap. 262 (HB 700)** changes from 49 to 99 the maximum number of eligible employees of an employer considered to be a "small employer" for purposes of certain health insurance provisions. Under Virginia law, in the small employer market, insurance carriers are required to (a) not exclude or limit coverage for preexisting conditions of an insured for more than 12 months from the insured's effective date of coverage; (b) guarantee the renewability of coverage (at the small employer's option); and (c) not exclude any member of the small employer group.

VA **1996 Va. Acts, Chap. 269 (HB 835)** when computing the length of a preexisting condition exclusion period under small employer market provisions, the act credits coverage provided under: Medicare; Medicaid; CHAMPUS; the Indian Health Service Program or any other similar publicly sponsored program; a group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the essential health benefit plan; or an individual health insurance policy, including coverage issued by a health maintenance organization, health services plan or fraternal benefits society that provides benefits similar to or exceeding the benefits provided under the essential health benefits plan.

VA **1996 Va. Acts, Chap. 550 (HB 1026)** requires individual insurance policies, contracts and plans to provide for the renewability of coverage at the sole option of the insured or policyholder, except as otherwise provided in the act. The act also requests the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to study additional reforms in the individual health insurance market.

Mandated Coverage

AK **1996 Alaska Sess. Laws, Chap. 74 (SB 253)** requires certain insurers to provide coverage for the costs of prostate cancer and cervical cancer screening. The act specifies the minimum coverage required to be provided and that the required coverage does not apply to a supplemental insurance contract covering a specified disease or offering limited benefits.

CA **1996 Cal. Stats., Chap. 556 (SB 686)** requires health plans and insurers to cover immunizations for children consistent with the most current version of the Recommended Childhood Immunization Schedule/United States.

CO **1996 Colo. Sess. Laws, Chap. 33 (HB 1241)** eliminates the requirement under the current newborn mandate that parents have family coverage before the child is born in order for the child to be covered.

CT **1996 Conn. Acts, P.A. 96-177 (SB 330)** prohibits individual and group health insurance plans from refusing to cover an applicant who once suffered from breast cancer if she remains breast cancer-free for at least five years before applying for coverage. The act allows insurers to require the applicant to submit to a physical examination at the time of application. The act exempts follow-up breast cancer examinations from the scope of a health plan's preexisting condition exclusion.

CT **1996 Conn. Acts, P.A. 96-185 (SB 68)** makes the Department of Mental Retardation (DMR), instead of the Education Department, the lead agency for the Birth-to-Three Program, a statewide early intervention system to provide services to all children from birth to three years old who are developmentally delayed or diagnosed with a condition highly correlated with developmental delay, such as Down's Syndrome or fetal alcohol syndrome. A sunset provision that would have terminated the program on June 30, 1996, is eliminated.

The act requires certain kinds of individual and group health insurance policies to provide at least $5,000 of annual coverage for medically necessary early intervention services provided as part of an individualized family service plan (IFSP). It also prohibits any such payments from being applied against a maximum lifetime or annual limit specified in the policy plan. The kinds of policies affected by this requirement include coverage for basic hospital expenses, basic medical-surgical expenses, major medical expenses, hospital or medical services under a plan and hospital and medical services to subscribers of a health care center.

The act also requires the DMR commissioner, in consultation with the Office of Policy and Management and the insurance commissioner, to adopt regulations providing public reimbursement for insurance policy or health benefit plan deductibles and co-payments applicable to early intervention services. The commissioner also must implement procedures to hold service recipients harmless for the effect of pursuit of payment against lifetime insurance limits.

DE	**Vol. 70 Del. Laws, H. Res. 85** requests the secretary of the Department of Health and Social Services to recommend the adoption of model legislation addressing the approval of off-label medical use of drugs for the purposes of health insurance reimbursements.
DE	**Vol. 70 Del. Laws, Sen. Concur. Res. 73** encourages health insurance policies to cover prescription strength prenatal vitamins under their prescription plans. This is not a mandate.
FL	**1996 Fla. Laws, Chap. 279 (HB 1239)** requires each health maintenance organization (HMO) and prepaid health plan to provide coverage for all medically appropriate and necessary equipment, supplies and services used to treat diabetes, including outpatient self-management training and educational services if the patient's primary care physician, or the physician to whom the patient has been referred who specializes in treating diabetes, certifies that the equipment, supplies, or services are necessary. Health insurance contracts may require that diabetes outpatient self-management training and educational services be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist under contract with or designated by the HMO or prepaid health plan. The Agency for Health Care Administration is directed to adopt standards for outpatient self-management training and educational services, taking into consideration standards approved by the American Diabetes Association. The act prohibits an HMO from discriminating against or failing to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of osteopathic physicians. Nothing in the act mandates that an HMO contract with a hospital.
FL	**1996 Fla. Laws, Chap. 282 (HB 397)** establishes the osteoporosis prevention and education program within the Department of Health and Rehabilitative Services to be administered by the State Health Office, in consultation with the Department of Elderly Affairs. The act requires health plans to cover osteoporosis screening, diagnosis, treatment and management. The act amends the list of exemptions to include certain group health insurance policies that are issued or delivered outside the state.
KY	**1996 Ky. Acts, Chap. 114 (HB 504)** requires insurers issuing individual or group or blanket health insurance policies in Kentucky that provide coverage for treatment of breast cancer by chemotherapy on an expense-incurred basis, or nonprofit hospital, medical-surgical, dental and health service corporations and all health maintenance organizations issuing contracts in Kentucky that provide hospital, medical, or surgical expense benefits for treatment of breast cancer by chemotherapy to also provide coverage for treatment of breast cancer by high-dose chemotherapy with autologus bone marrow transplantation or stem cell transplantation.
ME	**1996 Maine Laws, Chap. 592 (LD 1702)** requires health plans to provide coverage for diabetes supplies limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancents and the out-patient self-management training and educational services used to treat diabetes. The insured's treating physician or a physician who specializes in the treatment of diabetes must certify that the equipment and services are necessary and the training and education services must be provided through ambulatory diabetes education facilities authorized by the state's Diabetes Control Project within the Bureau of Health.
ME	**1996 Maine Laws, Chap. 617 (LD 1385)** requires all health plans to cover pap tests recommended by a physician, with a few exceptions for limited coverage plans.
MD	**1996 Md. Laws, Chaps. 375 and 376 (SB 181/HB 119)** require insurance plans to provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage must include all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry when reconstructive breast surgery is performed on the diseased breast.
MN	**1996 Minn. Laws, Chap. 446 (SF 1980)** requires insurance companies to cover prostate cancer screening. Under certain conditions, companies will be required to pay for a blood test used to identify the disease. Insurers will have to cover the prostate specific antigen (or PSA) test for all men

older than 50 and for men older than 40 who have symptoms of the disease or are in a high-risk group.

The act also requires all health insurers to offer at least one policy that allows consumers to seek treatment from the doctors of their choice. Holders of such a policy will not be bound to see doctors within a specific health care system or to follow a system's requirements for specialist referrals. For group coverage, it will be up to the employer--not individual employees--to decide whether to choose the coverage option.

MN **1996 Minn. Laws, Chap. 465 (HF 219)** amends provisions governing mandated coverage for children's health supervision services. The act extends current immunization coverage requirements and mandates coverage for immunization for children from birth to age six. The act requires that all health plans providing coverage to a Minnesota resident, issued, renewed, or continued on or after August 1, 1996, provide coverage for appropriate immunizations to children from ages six to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. In addition, the act mandates that health plans cover treatment for diagnosed Lyme disease. The act prohibits health plans from imposing a special deductible, copayment, waiting period, or other special restriction on treatment for Lyme disease that the health plan does not apply to non-preventive treatment in general.

NH **1996 N.H. Laws, Chap. 131 (HB 1431)** mandates coverage under individual policies for nonprescription enteral formulas for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, or motility of the gastrointestinal tract. Coverage must be provided when the prescribing physician has issued a written order stating that the enteral formula is needed to sustain life, is medically necessary and is the least restrictive and most cost effective means for meeting the needs of the patient. The act also mandates coverage under individual policies for nonprescription enteral formulas and food products required for those with inherited diseases of amino acids and organic acids. Coverage for inherited diseases of amino acids and organic acids must include food products modified to be low protein in an amount not to exceed $1,800 annually for any insured individual.

NH **1996 N.H. Laws, Chap. 193 (SB 590)** establishes a committee to study the feasibility of requiring insurers to cover early intervention services.

OK **1996 Okla. Sess. Laws, Chap. 102 (HB 2261)** requires all health insurance providers, except certain limited benefit plans, to provide coverage for bone-density testing for people whose medical histories indicate a high risk of osteoporosis, when the test is requested by a primary care or referral physician.

OK **1996 Okla. Sess. Laws, Chap. 125 (HB 3021)** mandates coverage for diabetes, including medications, supplies and diabetes education.

PA **1996 Pa. Laws, Act 191 (HB 1532)** enacts the Medical Foods Insurance Coverage Act and requires insurance plans to include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria administered under the direction of a physician.

RI **1996 R.I. Pub. Laws, Chap. 66 (HB 8842)** requires all health plans that cover physician services in a physician's office and all policies that provide major medical or similar comprehensive-type coverage to include coverage for prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the patient after a mastectomy. Coverage for prosthetic devices and reconstructive surgery are subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. Nothing in the act requires an individual or group policy to cover the surgical procedure known as mastectomy or to prevent the application of deductible or copayment provisions contained in the policy or plan, nor does anything in the act require that coverage under an individual or group policy be extended to any other procedures. Also, nothing in the act authorizes an insured or plan member to receive the coverage required by this act if that coverage is furnished by a non-participating provider, unless the insured or plan member is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

RI **1996 R.I. Pub. Laws, Chap. 106 (HB 8128)** provides that every health plan that covers physician services in a physician's office and every policy that provides major medical or similar comprehensive-type coverage, except for supplemental policies which only provide coverage for specified diseases and other supplemental policies, must include coverage for specific equipment and supplies for the treatment of insulin-treated diabetes, non-insulin treated diabetes and gestational diabetes, if medically appropriate and prescribed by a physician. Self-management education and education relating to medical nutrition therapy also must be covered. The act also details how an HMO medical service corporation, hospital service corporation, or insurer may impose copayments and/or deductibles.

SC **1996 S.C. Acts, Act 351 (H 4585)** prohibits an insurance policy which provides coverage for drugs from excluding coverage of any drug used for the treatment of cancer on the grounds that it has not been approved by the Food and Drug Administration (FDA) for the treatment of the specific type of cancer for which the drug has been prescribed as long as the drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature. The act does not alter existing law regarding policy provisions limiting the coverage of drugs lacking FDA approval, nor does it require coverage for any drug when the FDA contraindicates its use. The act does not require coverage for experimental drugs not otherwise approved by the FDA and does not affect reimbursement for drugs used in the treatment of any other disease or condition.

TN **1996 Tenn. Pub. Acts, Chap. 893 (H 151)** requires any health plan that provides hospital and surgical expense insurance and is delivered, issued, or renewed on or after July 1, 1995, to provide coverage for the treatment of phenylketonuria (PKU).

TN **1996 Tenn. Pub. Acts, Chap. 964 (H 2364)** authorizes the Department of Commerce and Insurance and the Department of Finance and Administration to promulgate permanent rules establishing minimum standards of coverage for maternity benefits offered by insurers. The rules are to establish standards sufficient to protect and promote the health, safety and well-being of both the postpartum mother and her newborn and recognize the relationship between the mother and physician.

The act provides that any health plan that provides coverage for pregnancy and/or maternity benefits may not be canceled or terminated due to the pregnancy of an enrollee. The act provides that if and only if, a person or the person's spouse is pregnant at the time the health insurance coverage is initially purchased, then pregnancy and/or maternity benefits for the current pregnancy may be denied as a preexisting condition. The act applies to all people who should have been entitled to coverage for such benefits on or after January 1, 1996.

TN **1996 Tenn. Pub. Acts, Chap. 969 (H 2484)** allows all health plans that provide coverage for accident and health services and are delivered, issued for delivery, amended or renewed on or after July 1, 1996, to also provide coverage to a qualified individual for scientifically proven bone mass measurement (bone density testing) for the diagnosis and treatment of osteoporosis. The act does not mandate coverage.

UT **1996 Utah Laws, Chap. 206 (SB 194)** provides that if an insured person has coverage for maternity benefits, the policy must cover any prenatal or maternity expenses of a birth mother or child, if the child is placed for adoption with the insured within 30 days of the child's birth. In the case of a managed care plan or HMO, if the birth mother is identified and arrangements for adoption begin before the child's birth, the insured must notify the plan. The plan may require compliance by the birth mother with the managed care terms and conditions of the contract in order for the insured to be entitled to the full prenatal and maternity benefit. If the birth mother does not comply, the amount of reimbursement to the insured may be limited to the applicable out-of-plan benefit.

If the insured changes insurance policies after medical services have been rendered to a birth mother or child, each insurer will be required to reimburse the insured for only the expenses that

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occurred during the time that the insured was covered for maternity benefits under that insurer's policy. If the insured is covered by two or more policies at the same time, expenses must be divided equally between the insurers, unless the terms of the policies, when considered together, provide for a different division.

If the adoption of the child placed with the insured is not finalized within one year of the child's birth, the insurer may seek reimbursement from the insured for any payment made under this act. If a policy offers optional maternity benefits, the insurer also must offer, on the same terms and conditions, optional coverage for prenatal or maternity expenses of a birth mother and child where the child is adopted by the insured and the adoption is finalized within nine months of the child's birth.

VA **1996 Va. Acts, Chap. 611 (SB 432)** requires health insurers and HMOs to provide coverage for annual pap smears.

WV **1996 W. Va. Acts, Chap. 148 (SB 312)** requires insurance companies to cover the treatment and management of diabetes on an equal basis with their coverage of other diseases. Coverage is required for both insulin dependent and non-insulin dependent persons, including those with gestational diabetes. Coverage must include diabetes self-management education. Any deductible or coinsurance shall apply on an equal basis with all other coverage provided by the insurer

Maternity Issues

AK **1996 Alaska Sess. Laws, Chap. 49 (SB 193)** requires an insurer that provides coverage for costs of birth to provide coverage for at least 48 hours following a vaginal birth and 96 hours following a Cesarean birth and provides that the mandated coverage may not be construed to require hospitalization or medical care if the mother and the health care provider agree to an earlier discharge.

CT **1996 Conn. Acts, P.A. 96-177 (SB 330)** requires each individual insurance carrier that offers maternity benefits to provide mothers and their newborn infants with at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours following a Cesarean delivery. The minimum inpatient stay begins at the time of delivery and any decisions to shorten it may be made only by the attending health care provider after conferring with the mother. Insurers must give policyholders written notice about the minimum hospital stay coverage in the next mailing to them, in the annual benefit summary, or by January 1, 1997, whichever is earliest.

If the mother and her newborn infant are discharged sooner than the minimum stay periods, the act requires coverage for follow-up visits--one within 48 hours of discharge and another within seven days of discharge. The follow-up visit must include physical assessment of the newborn infant, parent education and training in breast or bottle feeding, assessment of the home support system and performance of medically necessary and appropriate clinical tests. These services must be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric

DE **Vol. 70 Del. Laws, H. Conc. Res. 61** requests all health care providers, insurers and health maintenance organizations (HMOs) in Delaware to voluntarily adopt established medical criteria regarding postpartum care of mothers and their newborn infants, which provide: a) That each mother and her infant should be evaluated as a pair, in order to ensure that optimal timing of discharge may result from the evaluation. The decision should be made by the physician with input from the mother based on sound medical judgment. b) That mothers and infants should be discharged from the hospital when specific criteria are met, or mechanisms for follow-up evaluations are identified, or both. The specific criteria are identified in the Report of the postpartum Task Force dated March 14, 1996. c) That the guidelines established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics should govern the time of discharge. d) That all mothers and infants should receive one home visit at an appropriate time after discharge, regardless of the length of the hospital stay.

The resolution also requests the Delaware Health Care Commission to monitor readmissions of all mothers and infants within two weeks of their discharge, discriminating between avoidable and unavoidable readmissions. Accurate and current data are important for evaluation of the incidence, morbidity and cost of early discharge.

DE **Vol. 70 Del. Laws, Sen. Concur. Res. 73** encourages health insurance policies to cover prescription strength prenatal vitamins under their prescription plans. This is not a mandate.

DC **1996 D.C. Stats., Act 11-501 (Bill No. 11-598)** enacts the Newborn Health Insurance Amendment Act of 1996 and requires that all individual and group health insurance policies provide coverage for a minimum stay in a hospital or other birthing facility for a mother and child following the birth of a child, based on guidelines by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). The act specifies follow-up care for mothers released earlier to include parental education; assistance and training in breast or bottle feeding; and performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

FL **1996 Fla. Laws, Chap. 195 (SB 1860)** prohibits certain health insurance policies that provide maternity and newborn coverage from limiting coverage for the length of a maternity and newborn stay in a hospital or for follow-up care outside of a hospital to any time period that is less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider. Medical necessity decisions should be in accordance with prevailing medical standards and consistent with the proposed 1996 guidelines for perinatal care of the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists as proposed on May 1, 1996.

The act requires certain insurers to provide coverage for postdelivery care for a mother and her newborn infant at the hospital, at the attending physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. The services must include physical assessment of the newborn and mother and the performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards. The act also requires the insurer to communicate active case questions and concerns regarding postdelivery care directly to the treating physician or hospital in written form, in addition to other forms of communication. Insurers also must use a process that includes a written protocol for utilization review and quality assurance.

GA **1996 Ga. Laws, p. 739 (S 482)** requires every health benefit policy that provides maternity benefits to provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a Cesarean section for a mother and her newborn child in a licensed health care facility. Any decision to shorten the length of stay to less than the minimum must be made by the attending physician, obstetrician, pediatrician, or certified nurse midwife after conferring with the mother. The act also provides for post delivery care for a mother and her newborn.

IL **1996 Ill. Laws, P.A. 89-513 (HB 2557)** requires health and accident insurers providing maternity coverage to allow for a minimum of 48 hours of inpatient care for both mother and newborn following a vaginal delivery. For Cesarean deliveries, inpatient coverage must be provided for a minimum of 96 hours. A shorter inpatient stay may be allowed if the attending physician determines that a mother and newborn meet established guidelines for that shorter length of stay. In this case, there also must be coverage and availability for a post-discharge physician office visit or in-home nurse visit in the first 48 hours after discharge. People receiving medical assistance under the state Public Aid Code also must be provided with the same levels of coverage and care.

IN **1996 Ind. Acts, P.L. 194 (HB 1075)** requires all health insurance policies that provide maternity benefits and that are not pre-empted by the federal Employee Retirement Income Security Act (ERISA) to cover a minimum postpartum hospital stay for the mother and newborn that is consistent with the minimum period recommended by the American Academy of Pediatrics and the American

College of Obstetricians and Gynecologists. If an attending physician determines inpatient care is not medically necessary, the act allows for a shorter length for a postpartum hospital stay if both of the following conditions are met: (1) certain criteria for medical stability are met in the patient's attending physician's opinion; (2) the policy authorizes for the mother and newborn one postpartum visit to occur not later than 48 hours after discharge during which an adequate sample is collected for the hereditary and metabolic newborn screening. The postpartum visit also must include parent education, assistance with breast or bottle feeding and performance of any clinical tests routinely conducted by a hospital during the post-delivery period. The provider of the health insurance policy must provide notice of the minimum maternity benefits coverage to each enrollee of the policy or group contract.

IA **1996 Iowa Acts, Chap. 1202 (HF 2369)** requires insurance plans that are delivered, amended, or renewed on or after July 1, 1996 and that provide maternity benefits, to provide a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a Cesarean section for an insured mother and the newly born child in a licensed hospital. The act also provides that if the attending provider determines, following consultation with the mother, that the minimum inpatient stay is not necessary, the mother and newly born child may be discharged before completion of the minimum stay. If the mother and newly born child are discharged before completion of the minimum stay, the entity providing coverage for the post delivery stay is to provide coverage for a post discharge visit.

KS **1996 Kan. Sess. Laws, Chap. 96 (SB 573)** requires any health plan that provides coverage for maternity services, including benefits for childbirth, to provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by Cesarean section for a mother and her newborn child in a medical care facility. Any decision to shorten the length of inpatient stay must be made by the attending physician. No health plan may terminate the service or penalize, or provide financial disincentives in response to any attending physician who orders care consistent with the provisions of this act.

Any health plan that provides coverage for post delivery care to a mother and newborn child in the home is not required to provide coverage of the minimum lengths of inpatient care, unless it is determined to be medically necessary by the attending physician. The act requires all health plans to provide written notice as currently required, to all enrollees, insureds, or subscribers regarding the coverage required by this act. Finally, the act specifies that no policy, agreement, contract or certificate issued by a corporation to which this act applies may contain a provision which excludes, limits, or otherwise restricts coverage because Medicaid benefits are or may be available for the same accident or sickness.

KY **1996 Ky. Acts, Chap. 88 (HB 186)** requires a health benefit plan that provides maternity coverage to provide coverage for inpatient care for a mother and her newly-born child for a minimum of 48 hours after a vaginal delivery and a minimum of 96 hours after delivery by Cesarean section. The act provides that a health benefit plan that covers an initial postpartum visit is exempt if the attending physician, with agreement of the mother, authorizes a shorter length of stay if criteria for medical stability are met.

ME **1996 Maine Laws, Chap. 615 (LD 1732)** requires insurers that provide coverage for maternity benefits, including hospital stay, to provide that coverage in accordance with the attending party's determination that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care" published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The attending party may include the obstetrician, pediatrician, other physicians attending the mother and newborn, or a certified nurse midwife.

MD **1996 Md. Laws, Chaps. 396 and 397 (SB 433/HB 1271)** amend current law to require certain health insurers, health service plans and HMOs to provide inpatient hospitalization coverage for a mother and a newborn child for 48 hours after a vaginal delivery and 96 hours after a Cesarean section. The act authorizes a home visit by a registered nurse with experience in maternal and child health or community health nursing for any mother who requests a shorter hospital stay; an additional home visit if it is prescribed by the attending provider; and a home visit, as prescribed by the attending provider, for any mother who stays in the hospital for the minimum stay for which coverage is required. The act requires insurers to cover hospitalization, for up to four additional days for a newborn when the mother continues to be hospitalized for a medically necessary reason. In addition, the act prohibits an insurer from denying, limiting, or otherwise impairing participation on its panel or limiting privileges of a provider that advocates a longer hospital stay following a complicated childbirth or who prescribes a home visit. Finally, the law prohibits insurers from imposing a copayment or coinsurance requirement or a deductible on a postpartum home visit.

MN **1996 Minn. Laws, Chap. 335 (HF 2008)** requires insurance companies to cover a minimum of 48 hours of maternity inpatient care following an uncomplicated vaginal delivery and at least 96 hours of inpatient care following an uncomplicated Cesarean section. The act also prohibits health plans from providing any compensation or other nonmedical benefit to encourage a mother and newborn to leave the hospital early. Should a mother leave the hospital before 48 or 96 hours have elapsed, her insurance company must provide coverage for the option of one home visit by a registered nurse. Services provided by the nurse include parent education, training in breast and bottle feeding and conducting any necessary and appropriate clinical tests. The act does not apply to businesses that are self-insured or to health plans administered by the state, such as MinnesotaCare or Medical Assistance.

MO **1996 Mo. Laws, p. 770 (HB 1069)** requires health insurers and similar entities to cover inpatient care for the mother and child for 48 hours following a vaginal delivery and 96 hours following a Cesarean section. The coverage is required only if the policy covers maternity benefits. The time period can be shortened by the attending physician after consulting with the mother. The attending physician is required to use criteria developed by nationally recognized medical organizations to determine whether the time period should be shortened. If the period is shortened, the insurer is required to cover two visits by a registered professional nurse who is experienced in maternal and child health nursing. The schedule and location of the visits are determined by the attending physician. The act applies to policies that are delivered or renewed after January 1, 1997.

NH **1996 N.H. Laws, Chap. 75 (HB 1352)** requires each insurer that issues or renews any policy of accident and health insurance providing maternity benefits for hospital expense, medical-surgical expense, or major medical expense to comply with certain requirements. The length of hospital stay and the number of postpartum visits will be determined by the attending health care provider based on clinical information that demonstrates that the mother and infant are clinically stable and that appropriate care for the mother and newborn can be provided for upon discharge. Upon notification of the pregnancy by the insured to the insurer, the insurer must inform the pregnant woman in writing regarding the insurer's prenatal, maternity and postpartum benefits, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services and contraceptive counseling and referrals. The insurer must pay for medically necessary prenatal homemaker services when a woman is confined to bed rest or her activities of daily living are otherwise restricted on the recommendation of her attending health care provider who must consult with the applicable case manager. In cases where a length of hospital stay is shorter than the current minimum nationally accepted guidelines the insurer must pay for at least two postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases must take place. Postpartum visits must include a physical assessment of mother and infant including infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion and community resources. The insurer must pay for appropriate medically necessary postpartum homemaker services as determined by the attending health care provider who must consult with the applicable case manager. Insurers may not deny payment for services that are within standards of good and generally accepted medical practice as reflected by scientific and peer medical literature and recognized within the organized medical community in the state of New Hampshire.

NJ **1996 N.J. Laws, Sen. Res. 8** urges the commissioners of health and insurance to investigate health insurer contracts that pay hospitals for maternity care on per-case rather than per-diem, basis. The resolution is intended to ensure compliance by health insurers with the provisions of Pennsylvania's "48-hour" hospital maternity stay law.

NY **1996 N.Y. Laws, Chap. 56 (S 5742-A)** requires health insurers that provide maternity benefits to provide inpatient care for mothers and newborns for at least 48 hours after a vaginal delivery and 96 hours following a Cesarean section. Maternity coverage also must include at a minimum, parent education, assistance and training in breast or bottle feeding and newborn clinical assessments. If the mother chooses to be discharged earlier than the time periods established, the inpatient hospital coverage must include at least one home care visit, in addition to any home health care coverage available under the contract. The home care visit may be requested at any time within 48 hours of the time of delivery (96 hours in case of Cesarean section) and must be delivered within 24 hours after discharge or the time of the mother's request, whichever is later. This coverage may not be subject to deductibles, coinsurance, or copayments.

The act also specifies than when a general hospital provides maternity care, the hospital must offer inpatient care for not less than 48 hours after a normal birth, 96 hours following a Cesarean section and longer when medically necessary. The hospital must provide maternity care which includes parent education, assistance, training in breast and bottle feeding and the performance of any necessary maternal and newborn clinical assessments. The hospital may not charge any amount for these services in addition to the applicable charge for the maternity inpatient hospital admission. The act requires that the informational leaflet that every hospital and birth center must distribute to prospective maternity patients include an explanation of these special provisions and suggest that expectant mothers check their insurance policies for the details of their maternity coverage.

OH **1996 Ohio Laws, S. 199** requires health care policies that cover maternity benefits and the state Medicaid program to cover for a mother and her newborn child a minimum of 48 hours of inpatient care for a normal vaginal delivery, a minimum of 96 hours of inpatient care for a Cesarean delivery and a minimum amount of follow-up care. The act specifies that any decision regarding early discharge of a mother or newborn is the responsibility of the attending physician or nurse-midwife after consulting with the mother. The act also requires the Public Health Council to include in its rules prescribing laboratory tests to detect phenylketonuria in newborns any test that it determines is effective to detect the disorder in newborns younger than 48 hours old.

OK **1996 Okla. Sess. Laws, Chap. 164 (HB 2348)** requires health benefit plan contracts issued or renewed after July 1, 1996, to provide maternity coverage for at least 48 hours of inpatient care following a normal delivery, 48 hours of postpartum home care following a normal delivery in a home or birthing center and 96 hours of inpatient care following a Cesarean section.

PA **1996 Pa. Laws, Act 85 (HB 1977)** requires every health insurance policy that provides maternity benefits to provide coverage for a minimum of 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following a Cesarean section. A health insurance policy also may provide for a shorter length of stay, but only if the treating or attending physician determines that the mother and newborn meet medical criteria for safe discharge contained within guidelines developed by or in cooperation with treating physicians which recognize treatments standards, including those of the AAP and ACOG that determine appropriate length of stay based upon a number of health-related factors, including the demonstrated ability of the mother to care for the infant postdischarge and the availability of the postdischarge follow-up care to verify the condition of the infant and mother within 48 hours after discharge.

The act also requires the health insurance policy to provide coverage for home health care visits, in accordance with the recommendations of the treating physician, by a licensed health care provider whose scope of practice includes postpartum care. Home health visits shall include, at a minimum, parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests and the performance of necessary maternal and neonatal physical assessment. At the mother's sole discretion, any visits may occur at the facility of the provider. The act prohibits the health insurance policy from including any copayment, coinsurances or deductible amount for any postpartum home health care visits.

RI **1996 R.I. Pub. Laws, Chap. 246 and 260 (SB 2074 and HB 7239)** require all health plans that provide maternity benefits to provide hospital coverage for 48 hours after a vaginal birth and 96 hours after a Cesarean section for a mother and her newborn child. Any decision to shorten these minimum coverages must be made by the attending health care provider in consultation with the mother and in accordance with the guidelines for perinatal care published by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. In the case of early discharge, post-delivery care must include home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary clinical tests.

The act defines attending health care provider as the attending obstetrician, pediatrician, family practitioner, general practitioner, or certified nurse midwife attending the mother and newborn child. Any member who is denied benefits to be provided under this act may appeal in accordance with regulations of the Department of Health. No policy or plan can terminate the services, reduce capitation payment, or otherwise penalize an attending physician or other health care provider who orders care consistent with the provisions of this act.

SC **1996 S.C. Acts, Act 335 (S 1043)** prescribes hospital coverage periods for all group health insurance and HMO policies which provide hospital coverage for mothers and newborns. After a vaginal delivery, the mother and child may remain in the hospital for a period not to exceed the second postpartum day, not including the day of the birth. After a Cesarean section, they may remain in the hospital for a period not to exceed the third post-operative day, not including the day of surgery. These periods apply only if the attending physician finds it medically necessary. This act does not prohibit a physician from either requesting additional hospital time or from releasing the patient and child before expiration of the time prescribed.

SD **1996 S.D. Sess. Laws, Chap. 292 (SB 192)** provides that if a health insurance plan provides maternity coverage, the policy shall provide coverage for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following delivery by Cesarean section for a mother and her newborn child in a licensed health care facility. If the treating physician determines that the mother and the newborn meet medical criteria contained in "Guidelines for Perinatal Care, Third Edition," of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists as in effect on January 1, 1996, a health insurance policy may provide coverage for a shorter length of hospital inpatient stay for services related to maternity and newborn care if the coverage includes one follow-up visit in the first 48 hours after discharge to verify the condition of the mother and newborn.

UT **1996 Utah Laws, Chap. 38 (SB 23)** limits an insurer's ability to deny coverage for failure to obtain preauthorization for maternity care.

VA **1996 Va. Acts, Chaps. 201 and 155 (HB 87 and SB 148)** require insurers and HMOs that provide individual or group benefits for obstetrical services to provide coverage for inpatient care and subsequent postpartum home visits in accordance with the medical criteria outlined in the most current version of or official update to the "Guidelines for Perinatal Care" or the "Standards for Obstetric-Gynecologic Services." The act also requires the Virginia Medicaid Program and the state employee health plan to provide coverage in accordance with such guidelines or standards.

WA **1996 Wash. Laws, Chap. 281 (SB 6120)** requires every health carrier that provides coverage for maternity services to permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals and insurers. Covered eligible services may not be denied for inpatient, post delivery care to a mother and her newborn and follow-up care as ordered by the attending provider in consultation with the mother. Covered eligible services for newborns must be no less than the coverage for the child's mother, which can be for no less than three weeks, even if there is a separate hospital admission. Follow-up care decisions must be made by providers and mothers.

Medical Savings Accounts (MSAs)

CA **1996 Cal. Stats., Chap. 954 (SB 38)** conforms with federal law allowing small employers and self-employed individuals to create medical savings accounts.

ID **1996 Idaho Sess. Laws, Chap. 59 (HB 446)** amends existing law to exempt from the definition of salary for Public Employee Retirement System purposes any employer contributions to an employee's medical savings account up to a certain amount.

ID **1996 Idaho Sess. Laws, Chap. 60 (HB 502)** amends existing law on medical savings accounts to correctly define terms, provide that service charges are not withdrawals from the account, require nontaxable reimbursements to be made within the time specified, allow reversal of erroneous deposits within 30 days, provide rollover of funds to another account without tax consequences if made within 60 days and clarify depository reporting requirements.

ID **1996 Idaho Sess. Laws, H. Concur. Res. 45** directs the Department of Administration to solicit at least three bids for establishing a medical savings account program for health care coverage for state employees. The program must be comparable in quality to the current health care plan providing for an annual deductible limit of $110 and also must provide annual deductible limits of $2,000 for an individual, $2,500 for a two-person household, $3,000 for a family and no copayment after annual deductibles are met.

IN **1996 Ind. Acts, P.L. 66 (SB 122)** provides that an employer may assist in paying the deductible amount on an account the employer purchases to establish a medical savings account if the employer did not previously assist in paying for the employee's medical expenses.

LA **1996 La. Acts, P.A. 11 (HB 200)** allows a deduction from taxable income for contributions to a medical savings account, not to exceed the allowable deduction for a qualified higher deductible health plan. The act sets the deductible level at $1,250 to $2,500 for individual health coverage and $1,750 to $3,500 for an individual and his/her dependents. The act provides for adjusting the deductible limits annually for increases in the cost of living, as measured by the medical costs component of the Consumer Price Index. The act authorizes each employer to voluntarily offer continued coverage under the employer's existing health coverage and participation in a medical savings account program. The act authorizes an employer that previously did not grant accident and health insurance coverage under any other health plan, including an HMO, to establish a medical savings account program. The act also authorizes resident individuals to establish a medical savings account for the benefit of themselves or their dependents.

MS **1996 Miss. Laws, Chap. 491 (H 1057)** authorizes the Department of Finance and Administration to offer medical savings accounts as a plan option for health insurance coverage for state and public school employees after January 1, 1998. before offering such accounts as a plan option, the act directs the department to prepare and present to the Senate and House Insurance Committees by December 15, 1996, a comprehensive study, including a proposed implementation timetable and potential actuarial effects of such accounts on the existing state employee health plan. The study must include recommendations on employer and employee contribution levels, annual rollover of balances or withdrawals for nonmedical purposes and medical coverage for people who expend their account balances.

OH **1996 Ohio Laws, H. 179** provides for the establishment, operation and administration of medical savings accounts as a method to obtain health care in conjunction with a policy, plan, or contract or health insurance coverage. The act provides Ohio income tax benefits to individuals relative to the establishment and use of medical savings accounts and authorizes the superintendent of insurance to include coordination of benefits regarding medical savings accounts in the superintendent's rules on coordination of benefits.

OK **1996 Okla. Sess. Laws, Chap. 183 (HB 2188)** enables state employees to participate in the Oklahoma Medical Savings Account Program.

PA **1996 Pa. Laws, Act 179 (HB 1468)** amends the state's Medical Savings Account Act to exempt MSAs from state personal income tax in compliance with the federal Health Insurance Portability and Accountability Act of 1996.

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UT **1996 Utah Laws, Chap. 85 (SB 107)** clarifies the definition of eligible medical expenses and the operation of medical savings accounts and provides penalties for an account administrator's failure to comply with tax requirements. The act requires limited retrospective operation for taxable years beginning on or after January 1, 1996.

WV **1996 W. Va. Acts, Chap. 241 (SB 93)** updates the terms used in the personal income tax laws to bring them into conformity with federal income tax laws. The act states that medical savings accounts are not taxable trusts. Amounts drawn from medical savings accounts which are used for a purpose other than payment of medical expenses are to be added to federal adjusted gross income and a surtax is imposed. Subtracted from federal adjusted gross income are contributions to medical savings accounts not to exceed $2,000 plus interest earned on the account.

WI **1996 Wis. Laws, Act 453 (AB 545)** sets the maximum annual account amount for tax-exempt individual employee medical savings accounts at $2,000 for an individual, $2,000 for his or her spouse and $1,000 for each nonspouse dependent. The act defines a high cost-share health plan as any health insurance policy, certificate, or contract with deductibles, copayments, or other cost-sharing provisions of at least $1,500 if the insured's coverage is single or at least $3,000 if the insured's coverage is family. An employer that establishes a medical savings account on behalf of an employee or a self-employed person is not required to deposit in the account more than $2,000 per year for the employee's spouse or $1,000 per year for each nonspouse dependent of the employee if the employee's coverage is family. Beginning in 1998, the amounts will be increased each year.

The act restricts the medical savings account to specific uses, including to pay expenses for certain medical care, to purchase a long-term care insurance policy or pay long-term care expenses of the employee or self-employed person or any dependents. A person who provides medical care, long-term care, or a long-term care insurance policy that is to be paid with funds in a medical savings account, must bill the employee or self-employed person who is the holder of the account directly, rather than billing the account administrator of the medical savings account.

Other Consumer Protections

AL **1996 Ala. Acts, Act 651 (H395)** creates the Patient Right to Know Act, which requires any employer-sponsored health benefit plans, or any similar entity providing health coverage to furnish enrollees with a written description of the coverage, exclusions, services, medications, authorizations and financial responsibility for payment of coinsurance or other noncovered or out-of-plan services.

AL **1996 Ala. Acts, Sen. Jt. Res. 56** expresses the Legislature's view that all national and state health care reform legislation should include full disclosure provisions that require health insurance and managed care plans to make public the complete extent of benefits provided and to disclose any exclusion or restrictions of services including outpatient physician services; referral to specialty physicians and other providers; choice of pharmacy providers; diagnostic tests (including mammography exams); dental services, hospitalization, laboratory tests and services; Food and Drug Administration (FDA) approved or scientifically sound therapies; coverage of prescription drugs; rehabilitation services such as physical, occupational and vocational therapy; mental health services; long-term care; and the full range of reproductive services.

AZ **1996 Ariz. Sess. Laws, Chap. 132 (SB 1286)** requires health plans to provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required by the Emergency Medical Treatment and Active Labor Act without prior authorization by the plan, subject to applicable copayments, coinsurance and deductibles. A provider may not deny, limit or otherwise restrict a patient's access to medically necessary emergency services based upon the patient's enrollment in a health plan. The act allows a health plan to require, as a condition of coverage, prior authorization for health care services arising after the initial screening and stabilizing treatment. In such cases, the health plan must provide enrollees 24-hour access by telephone or facsimile.

CA **1996 Cal. Stats., Chap. 534 (SB 1875)** requires HMOs to report summary information on the disposition of grievances or complaints, categorizing the information by whether the subscriber is covered under Medicare, Medi-Cal, or through private coverage, as specified.

CA **1996 Cal. Stats., Chap. 979 (AB 1663)** enacts the Friedman-Knowles Experimental Treatment Act of 1996, which requires HMOs and health insurers to establish an external, independent review process to examine the plan's coverage decisions for individual enrollees with terminal conditions for which standard therapies have not been effective, as specified.

CA **1996 Cal. Stats., Chap. 1014 (AB 2649)** prohibits health care service plan contracts from containing incentive plans that act as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services covered under the contract.

CA **1996 Cal. Stats., Chap. 1024 (SB 1547)** revises disclosure requirements for health care service plans and disability insurers to fully disclose to enrollees, subscribers and insured persons coverage for substitute care, transitional in-patient care, or care provided in skilled nursing facilities, as specified.

CA **1996 Cal. Stats., Chap. 1091 (AB 3251)** requires health plans to file with their regulations a written policy describing how a plan determines if a second medical opinion is medically necessary and appropriate.

CT **1996 Conn. Acts, P.A. 96-067 (HB 5583)** prohibits individual and group health insurance policies from requiring the insured to get approval from his/her insurer, including HMOs, before calling a 911 emergency medical service when faced with a life- or limb-threatening emergency. The act defines a "life- or limb-threatening emergency" as any event that the insured believes threatens his life or limb in a way that creates a need for immediate medical care to prevent death or serious health impairment.

DE **Vol. 70 Del. Laws, Chap. 194 (HB 310)** permits the arbitration of health insurance coverage claims by the Insurance Department upon the request of the insured. Insurers offering approved arbitration procedures to their insured are exempted from arbitration by the Insurance Department. The act places a $75 cap on arbitration fees and authorizes the salary and benefits of the arbitration secretary to be funded by revenues generated by arbitration fees.

DC **1996 D.C. Stats., Act 11-228 (Bill No. 11- 168)** adds to the law providing for confidentiality of certain insurance information. The requirement that the superintendent maintain as confidential any documents or information received from the National Association of Insurance Commissioners or insurance departments of other states that is confidential in those jurisdictions. The superintendent may share information, including otherwise confidential information, with these groups so long as such other jurisdictions agree to maintain the same level of confidentiality available under District of Columbia law.

DC **1996 D.C. Stats., Act 11-495 (Bill No. 11-442)** sets forth standards for the formation, operation and regulation of health maintenance organizations in the District of Columbia. The act requires any entity that wants to establish an HMO to apply to the commissioner of insurance and securities for a certificate of authority in compliance with the act. The act requires applicants to meet numerous requirements, including submitting financial statements showing the applicant's assets, liabilities and sources of financial support; a sample of any contract form made or to be made, between any class of providers and the HMO and a copy of any contract between third party administrators, marketing consultants, or people responsible for day-to-day operations; a financial feasibility plan that includes detailed enrollment projections, the methodology for determining dues to be charged during the first 12 months of operations certified by an actuary and other financial information; a description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances; and a description of the proposed quality assurance program.

Each HMO must establish procedures to assure that the health care services provided to enrollees will be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medial practice. Such procedures shall include mechanisms to assure availability, accessibility and continuity of care. HMOs must provide every group and individual contract holder with a group or individual contract, which may not contain provisions or statements that are unjust, unfair, inequitable, misleading, deceptive, or that encourage misrepresentation. The commissioner may adopt regulations establishing readability standards for individual contract, group contract and evidence of coverage forms. The act requires every HMO to establish and maintain a grievance procedure, which has been approved by the commissioner to provide procedures for the resolution of grievances initiated by enrollees. An HMO must maintain records regarding grievances received since the date of its last examination of such grievances and the act allows the commissioner to examine grievance procedures. The act also details requirements to ensure protection against insolvency and regulates other aspects of HMO operations.

FL **1996 Fla. Laws, Chap. 180 (SB 742)** requires HMOs, prepaid health clinics, insurers and similar entities to maintain the confidentiality of psychotherapeutic claims provided by psychotherapists licensed under Florida statutes and related records and reports.

FL **1996 Fla. Laws, Chap. 391 (SB 2214)** creates a volunteer Statewide Managed Care Ombudsman Committee within the Agency for Health Care Administration to act as a consumer protection and advocacy organization on behalf of all health care consumers receiving services through managed care programs in the state. The act creates a district managed care ombudsman committee in each district of the Agency for Health Care Administration in the state of Florida that has staff assigned for the regulation of managed care programs. Each district committee is subject to direction and supervision from the statewide committee.

The act directs the statewide committee to receive quality of care complaints from the agency, assist the agency with the investigation and resolution of complaints, conduct site visits as the agency determines is appropriate and review existing or revised managed care quality assurance programs of the agency and make recommendations on how the rights of managed care enrollees are affected by such programs. A report to the Legislature is due no later than January 1, 1997, concerning activities, recommendations and complaints reviewed or developed by the statewide committee and district committees during the preceding year. Each district committee also may receive quality of care complaints from the agency, assist with the resolution of complaints and conduct site visits. A complaint may be referred by the agency to the district committee on a managed care program that may have inappropriately denied an enrollee a covered medical service, may be inappropriately delaying the provision of a covered medical service or is providing substandard covered medical services. The committee must establish and follow uniform criteria in reviewing information and receiving complaints. Each district committee must submit an annual report to the statewide committee on activities, recommendations and complaints reviewed during the year.

GA **1996 Ga. Laws, p. 751 (H 1338)** enacts the Patient Protection Act, with provisions for the certification and regulation of managed health care plans by the commissioner of insurance. The act requires certain disclosures to plan enrollees and amends the HMO disclosure requirement accordingly. The act specifies standards for access to health care services by enrollees. The act requires a health plan to provide for a utilization review program that stresses health outcomes, has written protocols based on current professional standards, provides review by physicians and appropriate health care providers of the process followed in the provision of such health care services, evaluates high-volume and high-risk services and the care of acute and chronic conditions, evaluates the continuity and coordination of care that enrollees receive and has mechanisms to detect both underutilization and overutilization of services. Health plans also must have a grievance procedure that provides the enrollee with a prompt and meaningful hearing on the issue of denial of a health care treatment or service or claim.

The act prohibits financial incentives that limit medically necessary and appropriate care. Plans are forbidden from penalizing a physician or health care provider for discussing medically necessary or appropriate health care. The act also specifies standards for accuracy and confidentiality of patient records.

The act uses the prudent layperson test to define emergency care services as services that are provided for a condition of recent onset and sufficient severity, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The act specifies that prior authorization is not required for the reimbursement of these services.

HI **1996 Hawaii Sess. Laws, Act 274 (HB 3785)** seeks to provide consumers with information so that they may make informed choices on health care coverage by requiring health plans to disclose coverages and benefits to current and prospective insured members and enrollees.

KS **1996 Kan. Sess. Laws, Chap. 169 (SB 477)** relates to the regulation of HMOs' business practices. The act changes solvency requirements and adds new sections relating to grievance procedures and utilization review. The act requires an HMO to provide in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage must include the definition of a grievance and how, where and to whom the enrollee should file a grievance. Upon receiving notification of a grievance related to payment of a bill for medical services, the HMO must acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time. The act requires the HMO to conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. Within five working days after the investigation is completed, the HMO must appoint someone not involved in the grievance to decide upon the appropriate resolution of the grievance.and notify the enrollee in writing of the HMO's decision and any right to appeal. If the HMO has established a grievance advisory panel, the HMO must notify the enrollee of his or her right to request the grievance advisory panel to review the HMO's decision.

In addition, the act requires an HMO that requires prior authorization before making payment for the treatment of medical emergency conditions, to provide enrollees with a toll-free telephone number answered 24 hours per day, seven days a week. At least one person with medical training who is authorized to determine whether an emergency condition exists must be available at all times to make these determinations. An HMO should not base its denial of payment for emergency medical services solely on the failure of the enrollee to receive authorization before receiving the emergency medical service. If the participating provider is responsible for seeking prior authorization from the HMO before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than the enrollee's usual responsibility for copayments and deductibles. All disputes between an enrollee and an HMO must be resolved by means or the grievance procedures established by the HMO.

In the event a provider's participation in a plan is terminated for any reason, the act requires the HMO to establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers. The plan is to include provisions for the continuation of care to enrollees for a period of up to 90 days by a provider who is terminated from a network in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the enrollee has special circumstances such as a disability, a life threatening illness, or is in the third trimester of pregnancy. The provisions for the continuation of care must include guarantees that the enrollee will not be liable to the provider for any amounts owed for medical care other than any deductibles or copayment amounts specified in the certificate of coverage or other contract between the enrollee and the HMO. In the event the terminated provider is authorized to continue treating the enrollee, the HMO has an obligation to pay the terminated provider at the previously contracted rate for services provided to the enrollee.

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Finally, the act amends the terms "individual practice association" and "medical group" or "staff model" to include surgeons and other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists.

KY **1996 Ky. Acts, Chap. 286 (SB 285)** requires health maintenance organizations to deposit with the state cash or securities in the amount of $500,000 so that obligations to enrollees will be performed.

KY **1996 Ky. Acts, Chap. 353 (SB 49)** amends existing law relating to health insurance plans, including HMOs, to require patients and health care providers to be notified of their right to appeal adverse determinations of private review agents to reduce or deny payment of health benefits. The act requires all insurance companies to provide, upon request from the Cabinet for Human Resources, information on Medicaid-eligible policyholders and dependents to be used to determine the availability of other medical benefits in order to ascertain that Medicaid is the payer of last resort.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** requires health plans, including managed care plans, operating in the state to meet certain requirements regarding reporting and disclosure, utilization review, grievance procedures and quality of care. The act requires managed care plans to demonstrate adequate access to providers and health care services within the plan in accordance with standards developed by the Bureau of Insurance. Managed care plans also must use objective standards for the credentialing of providers, provide written statements of all decisions regarding credentialing and maintain an appeals process for providers. Managed care plans are prohibited from terminating, refusing to contract with, or otherwise disciplining providers participating in the plan when the provider advocates for medically appropriate care for plan enrollees.

The act requires health plans to provide prospective and current enrollees and providers specified information about the terms and conditions of the plan to enable those people to make informed decisions regarding their choice of plans. In addition to information about services covered, services not covered, copayments and deductibles, restrictions on particular provider types, how the plan addresses the provision of appropriate and accessible care in a timely fashion and other details, the plans must provide information about procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or formulary, if any.

MD **1996 Md. Laws, Chap. 47 (HB 245)** prohibits a health network from denying health care services to any enrollee on the basis of gender, race, age, religion, or national origin, or a protected category under the Americans with Disabilities Act. Health network is defined as any entity that holds a certificate of authority under the insurance code or that is organized to provide health care services to individuals or an enrolled population in a regional or service area.

MD **1996 Md. Laws, Chap. 503 (HB 859)** requires non-participating providers to submit to an HMO the appropriate documentation of a member's medical complaint and the services rendered. The act also requires HMOs to reimburse hospital emergency facilities and providers (minus the applicable copayment) for medically necessary services provided to an HMO enrollee, if the HMO authorized, directed, referred, or allowed the use of the emergency facility and the services are related to the condition for which the member was allowed to use the emergency facility. The act stipulates that a provider is not required to obtain prior authorization or approval for payment from an HMO in order to obtain reimbursement. The act authorizes the hospital, provider, or insurer that has reimbursed a provider to collect or attempt to collect payment from an enrollee for a medical condition that is determined not to be an emergency.

The act requires HMOs to provide to members a statement of the potential responsibility of the member to pay for services the member seeks to obtain from a provider, including a physician or hospital, that does not have a written contract with the HMO. In addition, HMOs must provide members with a description of procedures to be followed for emergency services, including: the appropriate use of hospital emergency facilities, the appropriate use, location and hours of operation of any urgent care facilities operated by the HMO, the potential responsibility of subscribers and enrollees for payment for emergency services or nonemergency services rendered in a hospital emergency facility.

MD **1996 Md. Laws, Chap. 529 (HB 1207)** changes the external quality review process for HMOs, which had been conducted exclusively by the Department of Health and Mental Hygiene to authorize the department to accept all or part of a report of an approved accrediting organization, such as the National Committee for Quality Assurance and the Joint Commission on the Accreditation of Health Care Organizations as meeting its external review requirements for HMOs.

The act also requires the secretary of health and mental hygiene to adopt regulations for a primary source verification system. Primary source verification is the process used to ensure the truth and accuracy of documents and information submitted by a physician who is applying for practice privileges, entering into a contract, or seeking employment with a hospital, HMO, or other health care facility.

MD **1996 Md. Laws, Chap. 548 (HB 1374)** prohibits insurance carriers from using reimbursements (withholds) to create incentives for limiting health care, prohibit contract provisions requiring providers to indemnify carriers from causes of action over coverage decisions or negligent acts by carriers and establish ground rules for practice profiling of providers by carriers.

The act also creates a task force to study patient and provider appeal and grievance mechanisms. The task force is to evaluate the use and effectiveness of patient and provider grievance and appeal mechanisms currently in law that are used to appeal decisions of HMOs and make recommendations on the need for legislative action. The task force is to report by October 15, 1996.

MD **1996 Md. Laws, Chap. 549 (HB 1390)** directs the Health Resources Planning Commission to examine the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. A report on the results of the commission's investigation, together with any resulting policy recommendations, is due on or before November 1, 1996.

MD **1996 Md. Laws, Chap. 647 (HB 1148)** directs the insurance commissioner to review rate and form filings by HMOs. The act provides grounds for disapproval of a filing by the commissioner, who is required to give notice of disapproval within 60 days after a filing and explain the statutory or regulatory basis for disapproval. The act directs the commissioner to disapprove any form filed or withdraw approval of any previous approval if the form does not comply with requirements or applicable regulations; contains any inconsistent or inapplicable clauses, exceptions, or conditions that affect the risk purported to be assumed in the general coverage contract; or has any title, heading, or other indication of its provisions that is likely to mislead the subscriber or member. The commissioner also may disapprove any form that is substantially illegible, provides benefits that are unreasonable in relation to the premium charged, or includes provisions that are inequitable or lack any substantial benefit to the subscriber or member.

MA **1996 Mass. Acts, Chap. 8 (HB 5347)** requires, in cases pertaining to mental health treatment, that insurers obtain written, informed consent before disclosing information other than the patient's name, diagnosis, date and type of service.

MI **1996 Mich. Pub. Acts, Act 518 (HB 5574)** amends the "Prudent Purchaser Act," which regulates agreements between health care providers and health organizations, including insurers, hospital service corporations, medical care corporations, health care corporations, dental care corporations and third-party administrators. The act specifies procedures that are designed to notify health care providers located in the geographic area served by the organization of the acceptance of applications for participation including publication in a newspaper and specified time frame for notice and application.

The act also requires an organization that establishes a prudent purchaser agreement to disclose in writing to all purchasers of its coverage and to all covered members of its plans upon request the financial relationships between the organization and its participating health care providers, health care facilities, or other similar entities, including whether a fee-for-service arrangement exists;

whether a capitation arrangement exists; or whether payments to providers are made according to how well the provider meets criteria regarding costs, quality, patient satisfaction, or other criteria.

MI **1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573/HB 5571/SB 1166)** enact requirements for HMOs (Act 472), health care corporations (Act 516) and insurers (Act 547). The acts require HMOs, insurers and health care corporations to provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the organization's contract. The form must provide a clear, complete and accurate description of the service area; covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs; emergency health coverages and benefits; out-of-area coverages and benefits; an explanation of enrollee financial responsibility for copayments, deductibles and any other out-of-pocket expenses; provision for continuity of treatment in the event a provider's participation terminates; the telephone number to call to receive information concerning enrollee grievance procedures; and a summary listing of the information available upon request about the HMO, insurer of health care corporations and their providers. Such information must include the current provider network in the contract's service area; the professional credentials of participating health professionals; any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit and provider and if applicable, by specific service, benefit, or type of drug; indication of the financial relationships between the HMO or health care corporation and any closed provider panel including whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant; whether a capitation arrangement exists; or whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

The acts also concern grievance procedures. Acts 472 and 547 require that by October 1, 1997, HMOs and insurers must establish an internal formal enrollee grievance procedures for approval by the Insurance Bureau that includes all of the following: that when an adverse determination is made, a written statement containing the reasons for the adverse determination will be provided to an enrollee; that a written notification of the grievance procedures will be provided to an enrollee when the enrollee contests an adverse determination; that a final determination will be made in writing by the organization not later that 90 calendar days after a formal grievance is submitted by an enrollee; that an initial determination will be made by the HMO not later than 72 hours after receipt of an expedited grievance; and that an enrollee has the right to a final appeal to the department."Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied. Act 516 requires health care corporations to establish an expedited grievance procedure to provide that an initial determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. An expedited grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a normal grievance would acutely jeopardize the life of the member. The act also specifies other procedures for handling grievances.

MN **1996 Minn. Laws, Chap. 304 (HF 2044)** makes clear that insurance companies and HMOs may not retroactively cancel, rescind, or terminate the coverage of an employee, dependent, or other person covered under a group plan without the affected person's written consent. The act applies to group health and life policies, including group accidental death and dismemberment policies and disability policies.

NJ **1996 N.J. Laws, Chap. 126 (SB 695)** enacts the Genetic Privacy Act, which documents that genetic information is personal information that should not be collected, retained or disclosed without the individual's authorization. The act also declares no person shall discriminate against anyone on the basis of genetic information or the refusal to submit to a genetic test in cases of issuance, withholding, extension, or renewal of any hospital confinement or other insurance coverage; underwriting or determining insurability for a policy of life insurance, an annuity, or disability income insurance contract; and employment of an individual.

The act states no person shall obtain genetic information from an individual or from an individual's DNA sample without first obtaining informed consent. This requirement does not apply to genetic information obtained by or for law enforcement agencies whose purpose is to establish the identity of a person in the course of a criminal investigation/prosecution, individuals trying to determine paternity, determination of deceased individuals and anonymous searches. Finally, the act provides definitions for "genetic characteristic," "genetic information," and "genetic test."

NM **1996 N.M. Laws, Sen. Jt. Mem. 28** directs the Social Services Department and agencies to include consumers and providers in decision-making on block grant distribution and managed care.

NM **1996 N.M. Laws, Sen. Jt. Res. 31** resolves that the Department of Health study the feasibility of expanded emergency medical services in rural, medically underserved communities throughout the state as one major asset to be included in any managed care plans for the area. The department is requested to report its findings to the interim legislative health and human services committee at its October 1996 meeting.

NY **1996 N.Y. Laws, Chap. 497 (S 4293-D)** enacts a new section of the Civil Rights Law that prohibits genetic testing on a biological sample taken from an individual without prior written informed consent. The act identifies the numerous elements to be contained in the consent, including a general description and a statement of the purpose of the test, information on the significance of a positive test result, a list of persons and organizations who will receive the test results and signature of the individual being tested. The act specifies that any further disclosure of genetic test results to persons or organizations not named on the informed consent requires the further informed consent of the test subject.

The act applies to any laboratory test of human DNA, chromosomes, genes, or gene products to diagnose the presence of a genetic variation linked to a predisposition to a genetic disease or disability in the individual or his or her offspring, including a DNA profile analysis. The act exempts any test of blood or other medically prescribed test in routine use associated with a genetic variation, unless conducted purposely to identify such genetic variation. The act deems all records, findings and results of any genetic test to be confidential and prohibits them from being disclosed without the written informed consent of the subject.

The act enacts parallel provisions in the insurance law regulating insurers' requests for and use of genetic testing and stipulates that no authorized insurer may request or require an individual proposed for insurance coverage to be the subject of a genetic test without prior written informed consent.

NY **1996 N.Y. Laws, Chap. 705 (S 7553)** enacts comprehensive new provisions governing the administration of managed health care in order for the commissioner of health to fulfill statutory responsibilities regarding oversight of the quality of care delivered through managed care organizations, including HMOs, prepaid health services plans (PHSPs) and some indemnity insurers who are writing policies with managed care features. The act intends to do the following: make available to health care consumers more detailed information concerning their health insurance coverage options; establish a comprehensive set of standards for the grievance procedures of HMOs and insurers offering managed care; establish due process protections for health care providers participating in the network of an HMO or an insurer; ban limitations imposed by HMOs or insurers on a health care provider's right to advocate to the HMO or insurer on behalf of the patient (so-called "gag orders"); ensure that HMOs maintain sufficient capacity to meet the needs of enrollees; provide patients with better access to needed specialty care under HMO and other managed care products and clearer standards for the use of emergency care; establish a comprehensive set of standards for the performance of utilization review under HMO and health insurance products; ensure that HMOs report certain quality-related information on the providers in their networks to appropriate professional disciplinary bodies; and guarantee access to patient-specific medical information from HMOs by the commissioner of health for quality assurance and oversight purposes.

OK **1996 Okla. Sess. Laws, Chap. 335 (SB 1166)** prohibits hospitals and other providers from charging patients the difference between the discounted rate paid by managed care plans and the full cost of the services provided. The measure also requires insurers and health plans to disclose the

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calculations on which a copayment is based and to base the copayment on either the amount charged to the insurer or the amount actually paid by the insurer, whichever is less.

OK **1996 Okla. Sess. Laws, H. Concur. Res. 1113** creates the Task Force on Prevention of Genetic Discrimination to study issues in genetic discrimination in insurance and employment.

PA **1996 Pa. Laws, Act 112 (HB 1415)** requires insurers to provide reimbursement for "medically necessary" treatment received in an emergency room. The act defines "medical emergency" as a medical condition with acute symptoms of severity or severe pain for which care is sought as soon as possible after the medical condition becomes evident to the patient or the patient's parent or guardian; and the absence of immediate medical attention could result in placing health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any body part, or other serious medical consequences. The act requires a hospital emergency room to provide an insurer with any claim for reimbursement of services information on the presenting symptoms of the insured as well as the services provided. An insurer must consider both the presenting symptoms and the services provided in processing a claim for reimbursement of emergency services.

RI **1996 R.I. Pub. Laws, Chap. 41 (HB 8172)** enacts the Health Care Accessibility and Quality Assurance Act, which requires certification of health plans and establishes the process for certification and the procedures for review and recertification. The act requires health plans to provide written statements to the enrollees regarding their right to seek a second opinion and reimbursement, if applicable. The act requires the plan to disclose information on the appeals process, confidentiality of medical records, freedom from discrimination, prior authorization requirements, financial arrangements for capitation or other risk sharing arrangements with existing providers, written criteria regarding access to emergency services, plan costs for a defined list of health care services, the ratio of complaints received to the total number of people covered, the ratio of the number of prior authorizations denied to the number of prior authorizations required and a comprehensive list of providers. The act requires plans to develop and maintain credentialing criteria and other related matters. To help ensure a patient's ability to make informed health care decisions, the act requires the director of the Department of Health to promulgate regulations to provide for standardized definitions and provides a list of terms that should be standardized. The act makes clear that no definition is to be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under any contract.

The act makes it unlawful for a health plan to refuse to contract with or compensate an otherwise eligible provider or non-participating provider for covered services solely because that provider has in good faith communicated with his or her patients regarding the provisions, terms, or requirements of the insurer's products as they relate to the needs of that provider's patients.

RI **1996 R.I. Pub. Laws, Chap. 309 (SB 2579)** provides that no contract between an HMO and a physician for the provision of services to patients may require that the physician indemnify or hold harmless the HMO for any expenses and liabilities, including without limitation judgments, settlements, attorneys' fees, court costs and any associated charges incurred in connection with any claim or action brought against the plan based on the HMO's management decisions, utilization review provisions, or other actions which influenced the physician in his or her decisions and actions to provide or withhold medical treatment for any patient.

RI **1996 R.I. Pub. Laws, Chap. 343 (SB 2575)** amends provisions governing confidentiality of health care information and prohibits insurance companies, managed care facilities and managed care contractors writing policies in the state from providing to any medical information data base information related to enrollees that is personal in nature, could reasonably lead to their identification and is not essential for the compilation of statistical data related to enrollees. Any person who violates these confidentiality provisions is liable for actual and punitive damages. The act provides for penalties and fines and authorizes the court to award a reasonable attorney's fee at its discretion to the prevailing party in any civil action for violation.

RI **1996 R.I. Pub. Laws, Chap. 401 (H 8462)** adds definitions of managed care plan, managed care contractor and participating provider to the current law on confidentiality of health care information. The act prohibits all managed care entities and managed care contractors writing policies in the state from providing any personal information related to enrollees that could reasonably lead to identification of an individual and is not essential for the compilation of statistical data related to any international, national, regional or local medical information data base. This act does not restrict or otherwise prohibit the transfer of information to the Department of Health to carry out its statutory duties and responsibilities.

SD **1996 S.D. Sess. Laws, Chap. 296 (HB 1057)** requires the establishment of grievance procedures by utilization review organizations and managed care plans and provides for standards. Each managed care plan or utilization review organization must establish and maintain a grievance system, approved by the director after consultation with the secretary of the Department of Health, which may include an impartial mediation provision, to provide reasonable procedures for the resolution of written grievances initiated by enrollees concerning the provision of health care services. Mediation is to be made available to enrollees unless an enrollee elects to litigate a grievance before submission to mediation. No medical malpractice damage claim is subject to arbitration under the act. Each managed care plan or utilization review organization must provide that if a grievance is filed that requires a review of services authorized to be provided by a practitioner or if a grievance is filed that requires a review of treatment that has been provided by a practitioner, the review must include a similarly licensed peer whose scope of practice includes the services or treatment being reviewed.

UT **1996 Utah Laws, Chap. 181 (SB 87)** amends provisions governing health care claims practices. The act provides that when a service is covered by more than one individual or group health insurance policy all insurers covering the insured have the responsibility to pay valid health care claims in a timely manner according to the terms and limits specified in the policies. In regard to a health care provider billing an insured for services covered by health insurance policies, the act specifies that a provider may not make any report to a credit bureau, use the services of a collection agency, or use methods other than routine billing or notification for specified periods of time.

The act directs the commissioner of insurance to make rules governing disclosure to the insured of customary charges by health care providers on the explanation of benefits as part of the claims payment process. These rules must be limited to the form and content of the disclosures on the explanation of benefits and must include a requirement that the method of determination of any specifically referenced customary charges and the range of the customary charges be disclosed and a prohibition against an implication that the provider is charging excessively if the provider is a participating provider and prohibited from balance billing.

VT **1996 Vt. Acts, Act 180 (S 345)** combines the administration of health care and the quality and cost control oversight into one department. The act changes the administration of health care by terminating the Hospital Data Council and Health Policy Council and creating two new bodies: first, a public oversight commission to review hospital budgets and certificate of need applications and to make recommendations in that regard to the commissioner; and second, a technical review panel to advise the commissioner and the Health Oversight Commission on technical matters related to unified health care budget, resource allocation, utilization review, hospital budgets, quality assurance, the state health plan and other appropriate matters related to the administration of health care. The act also changes the thresholds that trigger certificate of need review. The act also creates more specific quality control and consumer protection requirements for managed care organizations and requires the Department of Banking, Insurance Securities and Health Care Administration to contract with Vermont Program of Quality in Health Care Inc. to implement and maintain a statewide quality assurance system of health care services rendered in Vermont. Under the act, the cost of this system shall be shared by the state and other health insurers and health care provider organizations.

VA **1996 Va. Acts, Chap. 776 (HB 1393)** establishes procedures for establishing and using health care provider panels. The act requires sponsors of such panels (defined by the act as "carriers") to publicize their intentions to develop panels and to provide applications and the relevant terms and conditions for participation on provider panels to health care providers seeking admission to them. Additional provisions require notice to (i) covered individuals regarding provider panel status changes and (ii) purchasers of health benefit plans providing a description of all types of payment arrangements that a carrier uses to compensate providers, including withholds, bonus payments, capitation and fee-for-service discounts. The act also prohibits contracts between a carrier and a provider from requiring that the provider (i) as a condition of participation on the panel, waive any right to seek legal redress against the carrier and (ii) indemnify the carrier for the carrier's negligence, willful misconduct or breach of contract (if any). The act further provides that such contracts (i) may not prohibit, impede or interfere in the discussion of medical treatment options between a patient and provider and (ii) must permit and require the provider to discuss medical treatment options with the patient. Finally, the act requests the Joint Commission on Health Care to study the need to require a point-of-service option in managed care plans and other issues relating to the impact of provider panels.

WA **1996 Wash. Laws, Chap. 312 (SB 6392)** requires that the health carrier must disclose whether a plan provider is restricted to prescribing drugs from a plan list, what drugs are on the list and the extent to which enrollees will be reimbursed for drugs that are not on the list. In addition, the health carrier must disclose procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services, a written description of any reimbursement or payment arrangements between a carrier and a provider, circumstances under which the plan may retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies, a copy of all grievance procedures for claim or service denial and for dissatisfaction with care and descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists. The act grants immunity from civil liability to organizations that exercise due diligence in preparing documents that compare health carrier coverage. The insurance commissioner is prohibited from promulgating rules regarding these provisions.

WV **1996 W. Va. Acts, Chap. 144 (SB 465)** requires that health insurance policies include coverage for emergency services with the same deductibles, coinsurance and other limitations as apply to other covered services. Preauthorization or precertification may not be required.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** amends the HMO act adding sections pertaining to quality assurance, reimbursement for ambulance services, rural HMOs and other reforms. The act requires each HMO to have in writing a quality assurance program that includes a written policy that addresses enrollees' rights and responsibilities, organizational arrangements and responsibilities for quality management and improvement processes, a documented utilization management program, written policies and procedures for credentialing and recredentialing physicians and other licensed providers who fall under the scope of authority of the HMO and any other criteria deemed necessary by the commissioner of insurance. In addition, the act requires all HMOs in existence for at least three years to obtain accreditation from a national accreditation and review organization.

The act provides that when an HMO enrollee receives covered emergency health care services from a noncontracting provider, the HMO is responsible for payment of the provider's normal charges for those health care services, exclusive of any applicable deductibles or copayments. In addition, the act expresses legislative intent that ambulance services in the state are performed by various volunteer emergency service squads, county operations and small businesses that may lack the sophistication and expertise required to negotiate a contract with an HMO for the provision of ambulance services and that the best interests of the state require the continued development and preservation of an emergency medical system to serve all the citizens of the state, including those who do not receive health care services through an HMO. The act directs the commissioner of insurance to promulgate legislative rules to regulate contracting for emergency medical services, including reimbursement for nonemergency transportation by non-participating providers and the appropriate use of 911 or community dispatching. The promulgated rules will be considered by the Legislature in the 1997 regular session.

The act expresses legislative intent that the provisions of the HMO Act and in particular, the financial requirements necessary to establish an HMO, may be too restrictive for small managed care organizations that intend to operate in rural areas of the state and that the public interest may be served by the development of less restrictive standards permitting the creation of rural HMOs.

The act directs the commissioner of insurance to develop and present to the joint committee on government and finance, not later than January 15, 1997, a proposal for legislation providing standards for the development and operation of rural HMOs to be considered during the 1997 regular session.

The act amends the definition of health care services to include chiropractic services and pediatric services. The definition of primary care physician is amended to allow a certified nurse-midwife to be chosen in lieu of a subscriber's primary care physician during the subscriber's pregnancy and for a period extending through the end of the month in which the 60-day period following termination of pregnancy occurs.

The act requires that certain additional information be added to the current requirements for the issuance of a certificate of authority whenever there is a change in membership of the governing body of an HMO or in the officers or those holding 5 percent or more of the common stock of the organization. The act further provides that all certificates of authority expire on May 31 of each year and that a fee shall be charged for each renewal of a certificate of authority.

Preexisting Conditions and Continuation of Coverage

CA **1996 Cal. Stats., Chap. 544 (AB 3142)** exempts from limitations on the use of preexisting condition exclusions specified disease policies or certificate of hospital confinement indemnity health insurance policies. The act provides that rejection for policies or certificates of specified diseases or policies or certificates of hospital confinement is not to be used to determine eligibility for the Major Risk Medical Insurance Program.

FL **1996 Fla. Laws, Chap. 223 (SB 910)** restricts the limitations that may be contained in a preexisting condition provision of a health insurance policy. The act stipulates that a health insurance policy's preexisting condition provision may not exclude coverage for a period beyond 24 months following the individual's effective date of coverage and may relate only to a pregnancy existing on the effective date of coverage or conditions that, during the 24-month period immediately preceding the effective date of coverage would cause an ordinarily prudent person to seek medical care, or for which medical care was recommended or received. In determining whether a preexisting condition provision applies to an eligible insured or dependent, credit must be given for the time the person was covered under previous coverage if the previous coverage was similar to or exceeded the coverage provided under the new policy and if the previous coverage was continuous to a date not more than 62 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

The act also requires guaranteed renewal of individual health insurance policies, except in specified cases, such as nonpayment of required premiums. The act also provides that an insurer that exercises its right of nonrenewal may not accept any new individual health insurance business for five years after it provides notice of such nonrenewal, unless a shorter period is approved by the commissioner. This provision applies to any hospital or medical policy or certificate, hospital or medical service plan contract, or HMO subscriber contract.

FL **1996 Fla. Laws, Chap. 319 (SB 14)** extends provisions under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to employers with fewer than 20 employees. The act also establishes the Florida Health Insurance Coverage Continuation Act which provides for continuation coverage for 18 months from the qualifying event, with the employee or dependent paying 115 percent of the applicable premium. The employer does not pay any of the cost for the continuation of coverage. The carrier is responsible for one mailing per household of any required document. The employee must elect coverage and pay the premium within 30 days of receiving the election form and premium notice from the carrier. The carrier may contract with the employer to perform the administrative duties of this act and the employer may, with the carrier's approval, delegate those duties to an entity.

ID **1996 Idaho Sess. Laws, Chap. 124 (SB 1383)** adds to existing law to provide for a conversion plan (which allows an individual to continue insurance when he/she leaves a group plan) for large and small group health insurance carriers that do not offer individual coverage.

ID **1996 Idaho Sess. Laws, Chap. 145 (SB 1322)** prevents a health benefit plan from denying, excluding or limiting benefits for covered expenses incurred more than 12 months following the effective date of the individual's coverage due to a preexisting condition. The act requires a health benefit plan to waive any time period applicable to a preexisting condition exclusion or limitation period for particular services for the period of time an individual was previously covered by qualifying coverage that provided benefits for such services, provided that the previous coverage was continuous to a date not more than 30 days before the effective date of the new coverage. The act does not preclude any waiting period applicable to all new enrollees under the health benefit plan. In the case of replacement coverage from the same carrier, a preexisting condition will be covered for the first 12 months for the lesser of the benefits payable under the new policy or the benefits which would have been payable under the prior policy. A health benefit plan may exclude coverage for late enrollees for the greater of 12 months or for a 12-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period does not exceed 12 months from the date the individual enrolls for coverage under the health benefit plan.

IN **1996 Ind. Acts, P.L. 190 (SB 117)** defines types of insurance policies that qualify and do not qualify as individual policies of accident and sickness insurance for purposes of applying preexisting condition exclusions to the transfer of insurance policies. The act provides that an individual who applies for an individual policy of accident and sickness insurance within 30 days after coverage under a small group health insurance policy or another individual policy of accident and sickness insurance expires is entitled to receive credit for time served under a preexisting condition clause in the expired policy. The act also provides that the period for determining if an employer meets the definition of small employer for purposes of small employer group health insurance is the previous calendar year. Each small employer insurer must annually submit to the Department of Insurance a copy of the actuarial certification the insurer is required to maintain. Portability provisions that apply to an employee of a small employer also apply to the employee's dependents.

KS **1996 Kan. Sess. Laws, Chap. 182 (SB 529)** amends group accident and health insurance statutes, including small group statutes, to allow an individual to enroll in a group outside the open enrollment period if the person had been eligible for, but declined coverage because the person was covered under another group, the person lost coverage due to termination of employment, death of a spouse, or divorce and the person sought enrollment in the eligible group within 31 days of the loss of coverage. No individual would be considered a late enrollee if the court ordered coverage for a spouse or minor child under a covered individual's policy.

KY **1996 Ky. Acts, Chap. 371 (SB 343)** increases the preexisting exclusion from six to 12 months and maintains modified community rating, but permits use of: gender (no more than a 50 percent variation from lowest to highest factor; occupation/industry (no more than a 15 percent variation); and for all case characteristics (no more than a 5:1 variation from highest to lowest rate factor). The act allows for a 10 percent discount for healthy lifestyles.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** Part B extends the continuity of coverage protection for people eligible for unemployment compensation from 90 days to 180 days and requires the Bureau of Insurance to set standards distinguishing excess insurance from basic insurance.

MA **1996 Mass. Acts, Chap. 297 (HB 6231)** limits preexisting condition exclusions and the look-back period to six months. Time served under another health plan will go towards satisfying the six-month exclusion. The act prohibits carriers from excluding eligible non-group individuals or their eligible dependents on the basis of age, occupation, actual or expected health condition, claims experience, or medical condition. Carriers are also prohibited from imposing any preexisting condition provision or waiting period in any guaranteed-issue health plan.

MI **1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573/HB 557/SB 1166)** prohibit an HMO, insurer or health care corporation from excluding or limiting coverage for a preexisting condition for an individual covered under a group contract. The insurance commissioner and the director of community health must examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by a preexisting condition limitation or exclusion for individuals covered under a nongroup contract and must report to the governor and the Legislature by May 15, 1997.

The acts also require HMOs, insurers and health care corporations to comply with guaranteed renewal requirements for both individual and group policies which means they must renew or continue in force the contract at the option of the individual or group with exceptions, such as fraud or nonpayment.

SC **1996 S.C. Acts, Act 435 (H 3870)** allows health insurance policies to contain a provision limiting coverage for preexisting conditions, so as to provide that policies of disability income insurance may exclude coverage for disabilities beginning during the first 12 months after the effective date of coverage which result from a preexisting condition. Whenever a covered person moves from one insured group to another, the insurer of the group to which the covered person moves must give credit for the satisfaction of the preexisting condition period or portion thereof already served under the prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous to a date not more than 30 days before the effective date of the new coverage. Service under a probationary waiting period required by the employer is not considered to interrupt continuous service.

SD **1996 S.D. Sess. Laws, Chap. 295 (HB 1310)** requires that, if an employer has an existing health benefit plan, the carrier must accept for coverage under the health benefit plan new employees and the dependents of new employees, if the new employee had qualifying previous coverage within the prior 30 days from the date the new employee is eligible for coverage. The coverage must be issued without exclusionary riders. The carrier is not required to provide coverage for new employees or dependents who are late enrollees or who have not had qualifying previous coverage within 30 days before applying for definition of eligible dependents.

VA **1996 Va. Acts, Chap. 269 (HB 835)** provides that when computing the length of a preexisting condition exclusion period under small employer market provisions, credit be given for coverage provided under: Medicare, Medicaid, CHAMPUS, the Indian Health Service Program or any other similar publicly sponsored program; a group health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the essential health benefit plan; or an individual health insurance policy, including coverage issued by a health maintenance organization, health services plan or fraternal benefits society, that provides benefits similar to or exceeding the benefits provided under the essential health benefits plan.

Protection for Domestic Violence Victims

DE **Vol. 70 Del. Laws, Chap. 250 (SB 128)** prohibits life or health insurers from using domestic abuse as a negative underwriting factor.

DE **Vol. 70 Del. Laws, Chap. 510 (SB 433)** prohibits discriminatory practices against victims of domestic violence by life, health, homeowners and automobile insurance companies.

IN **1996 Ind. Acts, P.L. 188 (SB 306)** prohibits discrimination against a person who has been the victim of domestic abuse, if the discrimination involves the issuance of life insurance, various forms of accident and sickness insurance, disability insurance, or a health maintenance organization contract.

MN **1996 Minn. Laws, Chap. 278 (SF 1815)** prohibits insurance companies from using domestic abuse as a negative underwriting factor for life or health insurance.

NH **1996 N.H. Laws, Chap. 40 (HB 1211)** prohibits insurers from denying an individual insurance of any type based solely on the fact or perception that the applicant is or may become a victim of domestic abuse.

NY **1996 N.Y. Laws, Chap. 174 (A 2769-E)** prevents insurers from denying, canceling, or refusing to issue any insurance policy to a person who has been a victim of domestic violence. The act specifies that domestic violence is not a designated preexisting condition which would allow for coverage to be denied or reduce, nor is the insurer allowed to require a greater premium or payment due to the fact that the person has been a victim of domestic violence. The act also prevents insurers from fixing a lower rate or discriminating in the fees or commissions of agents or brokers who write or renew policies of those who have been victims of domestic violence.

PA **1996 Pa. Laws, Act 24 (HB 1100)** prohibits insurers from discriminating against victims of domestic abuse.

TN **1996 Tenn. Pub. Acts, Chap. 723 (H 2925)** prohibits an insurer or health carrier from discriminating against a subject of abuse on the basis of that abuse status. All information about an applicant's or insured's abuse status must be kept confidential, except for purposes related to the provision of health services, administering claims, utilization review, case management, or where required by the commissioner of commerce and insurance or the court.

State-Sponsored Insurance Programs

AZ **1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)** changes the name of the medically needy and medically indigent program stabilization fund to the medical services stabilization fund. The act expands the use of money in the stabilization fund to be used to offset increases in the cost of providing levels of services to those eligible for Arizona Health Care Cost Containment System (AHCCCS) services through federal categories if the increase in costs is caused by a decrease in federal funding. The act makes a one-time transfer of $30 million from the medically needy account to the medical services stabilization fund.

Subject to the availability of funds in the medically needy account of the tobacco tax and health care fund, the act establishes the premium sharing demonstration project fund and the basic children's medical services program. The AHCCCS administration, contingent on the existence of the fund, is authorized to withdraw $20 million in FY 1996-97, 1997-98 and 1998-99 to be deposited in the fund to provide health care services to those eligible for the AHCCCS Premium Sharing Demonstration Program. The act establishes the six-member AHCCCS Premium Sharing Demonstration Project Implementation Committee to make recommendations to the governor, the Legislature, the secretary of state and the director of the Arizona Legislative Council by November 15, 1996, regarding the implementation of a premium sharing program. The act recommends that the committee address participant eligibility criteria, an income threshold that does not exceed 300 percent of the federal poverty level, the types of services to be provided and the entity that should be responsible for collecting participant premiums. At the direction of the committee, the AHCCCS administration is required to conduct actuarial studies that provide rate and premium sharing cost estimates.

Beginning FY 1996-97, the act annually transfers up to $5 million to the Department of Health Services (DHS) to establish contracts with eligible hospitals to provide for a basic children's medical services (BCMS) program, to provide health care services to indigent, uninsured or underinsured children who are not eligible for AHCCCS services. Up to two percent of the total funding is authorized to be used for administrative costs and additional money, as necessary, to perform program evaluations. Program money is required to be used to enhance the hospital's ability to provide additional services to eligible children and improve the delivery of inpatient, outpatient and specialized clinical services. The act sets out requirements for participating hospitals, including a sliding fee scale for eligible children. DHS is exempt from rule making requirements for the implementation of this program.

CA **1996 Cal. Stats., Chap. 792 (SB 661)** authorizes the Managed Risk Medical Insurance Board (MRMIB) to adjust premiums so that subscribers in the Major Risk Medical Insurance Program would pay additional subsidy amounts above the average program subsidy. The act authorizes MRMIB to increase maximum copayments and deductibles to enable them to provide coverage to additional subscribers.

CT **1996 Conn. Acts, P.A. 96-187 (HB 5024)** moves back, from July 1, 1995, to December 31, 1994, the date on which a child must have been enrolled in the Healthy Steps Program to be included in an extension of that subsidized health insurance program. Moving the enrollment date back reinstates coverage for eligible children whose coverage expired between December 31, 1994 and July 1, 1995. (Note: Healthy Steps is a public-private partnership to provide health insurance in the New Haven area. Children between the ages of birth and 17 are eligible if they live in the area, attend school, have no health insurance and are in families with adjusted gross income under 200 percent of federal poverty levels. The state contracts with Blue Cross/Blue Shield and Community Health Care Plan.)

FL **1996 Fla. Laws, Chap. 337 (HB 1813)** renames the Florida Healthy Kids Corporation Act the "William G. 'Doc' Myers Healthy Kids Corporation Act" and removes language that limits the program from operating at no more than 10 sites on a pilot basis. Amended language allows the program to designate sites without legislative approval and specifies that program services are limited to children.

GU **1996 Guam Laws, P.L. 23-76** funds the Catastrophic Illness Assistance Program within the FY 96 budget of the Department of Public Health, increases the benefit cap from $100,000 to $175,000 and requires the adoption of rules and regulations in accordance with the Administrative Adjudication Law to administer the program.

KS **1996 Kan. Sess. Laws, Chap. 98 (SB 441)** caps the premium rate that can be charged to Kansas Uninsurable Health Insurance Plan holders at 150 percent of the average premium rate charged for similar coverage in the private market. In addition, the act amends previous law to make assessments levied against insurers in the plan eligible for the 80 percent offset against the insurer's premium tax liability beginning after December 31, 1995, (a year earlier than previously authorized in law).

KS **1996 Kan. Sess. Laws, Chap. 130 (S 593)** relates to the right to coordinate benefits with a private carrier. When medical assistance is furnished or any other health care program funded by federal or state money to a person having private health care coverage, the Department of Social and Rehabilitation Services or any other state agency furnishing such medical assistance is entitled to be subrogated to the rights that the person has against the carrier of the coverage to the extent of health care services rendered. Such action may be brought within two years (previously three years) from the date that service was rendered.

MA **1996 Mass. Acts, Chap. 203 (HB 6107)** expands Medicaid eligibility for children under age 12 with family incomes under 200 percent of poverty. The act authorizes Medicaid benefits to be provided by means of a demonstration project known as MassHealth. The act also expands eligibility for the Children's Medical Security Plan to children from the current age 12 to 18, which covers Medicaid ineligible children on a sliding scale basis. The act increases the cigarette tax to 25 cents per pack, which also applies to cigars and pipe tobacco, to help fund both program expansions.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** delays from July 1, 1995, to October 31, 1997, the date that all managed care organizations must file biennial action plans describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. The act requires the commissioner to report on recommendations to the Legislature by January 15, 1997, identifying county social services and public health administrative costs for each target population that should be excluded from the overall capitation rate. The act requires the commissioner of human services to study and report to the Legislature by January 1, 1997, on the advisability of compensating clients on the public health care programs if a client has successfully reversed a

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private insurer's denial of health insurance. The report also must include recommendations on reducing the parental fees under current statutes if a parent has successfully reversed a private insurer's denial of insurance.

The act requires integrated service networks (ISNs), as a condition of licensure to participate in the medical assistance, general assistance medical care and MinnesotaCare programs. ISNs, which function as both health care provider and insurer, are required to submit proposals in good faith to service people who are eligible for these programs if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the ISN is less than the ISNs percentage of the total number of individuals enrolled in ISNs in the same region. Geographic regions will be defined by the commissioner of human services in the request for proposals. (See also "Medicaid" and "Special Health Care Needs" for additional information.)

NH **1996 N.H. Laws, Chap. 119 (SB 541)** exempts payments made by the Healthy Kids Corporation for insurance coverage for children from the insurance premium tax.

NJ **1996 N.J. Laws, Chap. 8 (SB 627)** changes certain provisions of the State Health Benefits Program to allow the use of managed care.

NJ **1996 N.J. Laws, Chap. 29 (AB 1590)** adds uninsured children to those eligible for Health Access New Jersey, a program that provides subsidized insurance for low-income working people and those temporarily unemployed. The act amends previous law to allocate to Health Access New Jersey $10 million in 1996 (down from $100 million) and $25 million in 1997 (down from $150 million).

OK **1996 Okla. Sess. Laws, Chap. 274 (SB 729)** modifies the state's high-risk insurance pool to provide insurance for people who might not otherwise be able to access coverage and limits eligibility to people who have had primary residence in Oklahoma for at least one year.

SD **1996 S.D. Sess. Laws, Chap. 286 (HB 1277)** creates the South Dakota Health Insurance Plan, to operate subject to the supervision and control of a board. People eligible for the plan are individuals who have been refused coverage due to a health condition by at least two health plans and do not have access to any other group coverage or publicly financed health plan. The board will develop the benefits package, exclusions, premium rates and other particulars of the plan.

UT **1996 Utah Laws, Chap. 250 (SB 111)** amends the state's Medicaid freedom of choice waiver to allow contracts with private insurers, including HMOs and other private health care delivery organizations. The act specifies that, to the extent permissible under the waiver, the plan should utilize private insurance plans and provides that the Division of Health Care Financing is not prevented from contracting with a health care delivery organization that is not financially at risk if the division determines that it is advantageous to do so.

LEGAL AND ETHICAL ISSUES

CA **1996 Cal. Stats., Chap. 790 (AB 2125)** requires the Department of Health Services, in consultation with the Department of Social Services and the appropriate federal agency or department, to establish and implement appropriate education, preventative and outreach activities focusing on new immigrant populations that traditionally practice female genital mutilation. The act provides that a person who commits a felony violation by an act of female genital mutilation, as defined, shall be punished by an additional term of imprisonment in the state prison for one year, in addition and consecutive to any other punishment prescribed by law.

DE **Vol. 70 Del. Laws, Chap. 250 (SB 128)** prohibits life or health insurers from using domestic abuse as a negative underwriting factor.

DE **Vol. 70 Del. Laws, Chap. 510 (SB 433)** prohibits discriminatory practices against victims of domestic violence by life, health, homeowners and automobile insurance companies.

DC **1996 D.C. Stats., Act 11-228 (Bill No. 11-168)** adds to the law providing for confidentiality of certain insurance information the requirement that the superintendent maintain as confidential any documents or information received from the National Association of Insurance Commissioners or insurance departments of other states which is confidential in those jurisdictions. The superintendent may share information, including otherwise confidential information, with these groups so long as such other jurisdictions agree to maintain the same level of confidentiality available under District of Columbia law.

FL **1996 Fla. Laws, Chap. 179 (SB 474)** requires physicians and midwives to offer HIV testing to all pregnant patients as the prevailing standard of care. Those who attend patients who have been offered but refused testing will be immune from liability arising from the subsequent transmission of HIV infection from the mother to the child.

FL **1996 Fla. Laws, Chap. 180 (SB 742)** requires HMOs, prepaid health clinics, insurers and similar entities to maintain the confidentiality of psychotherapeutic claims provided by psychotherapists licensed under Florida statutes and related records and reports.

HI **1996 Hawaii Sess. Laws, S. Res. 83** requests the Department of Health to develop standards and procedures to govern decisions to sterilize incapacitated minors in consultation with the State Council on Developmental Disabilities, the Protection and Advocacy Agency, the Hawaii chapter of the American College of Obstetrics and Gynecology, the Reproductive Rights Protection Committee, the Hawaii Health Care Association and the Hawaii Medical Association. The director of health is directed to report findings and recommendations, including proposed legislation, to the legislature 20 days before the convening of the regular session of 1997.

HI **1996 Hawaii Sess. Laws, S. Res. 226** requests the Department of Health to convene a panel to review the state's statutes governing the confidentiality of an individual's health care information.

ID **1996 Idaho Sess. Laws, Chap. 227 (H 553)** amends existing law to provide enhanced penalties for battery if the victim is pregnant and the defendant knows the victim is pregnant.

IL **1996 Ill. Laws, P.A. 89-646 (SB 1513)** amends the Public Aid Code to provide that a local governmental unit in any county may elect to provide, at a minimum, under the General Assistance Program, financial aid for emergency medical treatment, care and supplies only, deleting the term "necessary treatment, care and supplies required because of illness or disability." The act requires that the General Assistance rules of the local governmental unit must specify the emergency treatment for which financial aid is provided and must include medical treatment, care and supplies necessitated by a condition that is life-threatening, will result in significant and permanent physical impairment, or requires immediate attention to relieve significant present physical impairment, or requires immediate attention to relieve significant present physical pain and suffering. The act provides that a township, township supervisor, or township employee is not liable for injury caused by a decision to grant or deny aid under the Article on General Assistance.

IN **1996 Ind. Acts, P.L. 219 (SB 176)** provides that an individual who gratuitously supplies medical care at the scene of an emergency or accident is immune from civil liability for any personal injury that results from the care provided except in cases of gross negligence or willful or wanton misconduct.

LA **1996 La. Acts, H. Concur. Res. 52** urges the Congress and the president of the United States to utilize American influence in international relations to end female genital mutilation in those countries where these procedures are presently practiced upon unwilling individuals. The act requests that the United States grant political asylum to individuals who flee their homelands to escape female genital mutilation.

MI **1996 Mich. Pub. Acts, Act 287 (HB 5741)** provides that nothing in the school code shall be construed to authorize compulsory physical examination or compulsory medical treatment of pupils.

MI **1996 Mich. Pub. Acts, Act 304 (SB 598)** provides that in cases of child custody, a parent may not be denied access to records or information concerning his or her child because the parent is not the child's custodial parent, unless the parent is prohibited from having access to the records or information by a protective order."Records or information" includes, but is not limited to, medical, dental and school records, day care provider's records and notification of meetings regarding the child's education

NJ **1996 N.J. Laws, Chap. 126 (SB 695)** enacts the Genetic Privacy Act, which documents that genetic information is personal information that should not be collected, retained or disclosed without the individual's authorization. The act also declares no person shall discriminate against anyone on the basis of genetic information or the refusal to submit to a genetic test in cases of issuance, withholding, extension, or renewal of any hospital confinement or other insurance coverage; underwriting or determining insurability for a policy of life insurance, an annuity, or disability income insurance contract; and employment of an individual.

The act states no person shall obtain genetic information from an individual or from an individual's DNA sample without first obtaining informed consent. This requirement does not apply to genetic information obtained by or for law enforcement agencies whose purpose is to establish the identity of a person in the course of a criminal investigation/prosecution, individuals trying to determine paternity, determination of deceased individuals and anonymous searches. Finally, the act provides definitions for "genetic characteristic," "genetic information," and "genetic test."

NY **1996 N.Y. Laws, Chap. 497 (S 4293-D)** enacts a new section of the Civil Rights Law that prohibits genetic testing on a biological sample taken from an individual without prior written informed consent. The act identifies the numerous elements to be contained in the consent, including a general description and a statement of the purpose of the test, information on the significance of a positive test result, a list of persons and organizations who will receive the test results and signature of the individual being tested. The act specifies that any further disclosure of genetic test results to persons or organizations not named on the informed consent requires the further informed consent of the test subject.

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The act applies to any laboratory test of human DNA, chromosomes, genes, or gene products to diagnose the presence of a genetic variation linked to a predisposition to a genetic disease or disability in the individual or his or her offspring, including a DNA profile analysis. The act exempts any test of blood or other medically prescribed test in routine use associated with a genetic variation, unless conducted purposely to identify such genetic variation. The act deems all records, findings and results of any genetic test to be confidential and prohibits them from being disclosed without the written informed consent of the subject.

The act enacts parallel provisions in the insurance law regulating insurer's requests for and use of genetic testing and stipulates that no authorized insurer may request or require an individual proposed for insurance coverage to be the subject of a genetic test without prior written informed consent.

NY **1996 N.Y. Laws, Chap. 612 (S 6053-B)** establishes an adoption medical information subregistry in the adoption information registry in order for birth parents to provide certified medical information. The act stipulates that such information must be sufficient enough to also locate the adoptee's birth record. The act requires the Department of Health (DOH) to establish procedures by which a birth parent may provide medical information to the subregistry and by which an adoptee 18 years of age or older, or the adoptive parents of an adoptee who has not reached age 18, may access the nonidentifying medical information. The act describes how the information is to be entered into the subregistry and matched to people who request it.

The DOH is prohibited from soliciting or requesting medical information from a birth parent of the registration by an adoptee or adoptee's parent. No fee is to be required of the birth parent providing the information. The act establishes that the information registry's fee schedule for search and registry costs also applies to the subregistry.

OH **1996 Ohio Laws, S. 246** prohibits the sale of expired drugs, baby food and infant formula and also prohibits selling at a flea market a product bearing an expiration date or recommended sale or use date.

The act authorizes an individual who is certified to conduct diabetes education to possess insulin if the person is professionally licensed, certified, or registered by the state and diabetes education is within the individual's scope of practice; authorizes possession of hypodermic needles for educational purposes; and repeals the prohibition against discarding hypodermics before rendering them unusable.

OK **1996 Okla. Sess. Laws, H. Concur. Res. 1113** creates the Task Force on Prevention of Genetic Discrimination to study issues in genetic discrimination in insurance and employment.

RI **1996 R.I. Pub. Laws, Chap. 81 (SB 2317)** adds female genital mutilation to the felony assault law, specifically, the act applies the provisions and penalties of the Domestic Violence Prevention Act to anyone who circumcises, excises or infibulates the whole or any part of a woman's labia majora, labia minora or clitoris.

RI **1996 R.I. Pub. Laws, Chaps. 248 and 266 (SB 2245 and HB 7833)** expand and clarify current provisions governing confidentiality of health care information. The acts define confidential health care communication to mean a communication of health care information by an individual to a health care provider, including a transcription of any such information, not intended to be disclosed to third persons except if those persons are present to further the interest of the patient, reasonably necessary for the transmission of the communication, participating in the diagnosis and treatment under the direction of the health care provider, including members of the patient's family. Nothing contained in the acts may be construed to limit the permitted disclosure of confidential health care information and communications permitted by law. The acts also provide procedures for disclosure of confidential health care information in judicial proceedings.

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SC **1996 S.C. Acts, Act 450 (H 4614)** empowers the family court to order medical treatment for a child in danger of permanent harm or death because the parents refused to consent based on religious grounds.

TN **1996 Tenn. Pub. Acts, Chap. 842 (H 2342)** requires a doctor or health care provider to report cases in which it is learned that the alleged father of a pregnancy in a child less than 18 years old is at least four years older and not the spouse of the child. The report must be made in writing to the chief of police or sheriff within 24 hours of the discovery.

UT **1996 Utah Laws, Chap. 4 (HB 10)** requires local school boards to implement rules prescribed by the Department of Health for giving abnormal spinal curvature examinations to students. The rules must include exemptions for students whose parents or guardians feel such an examination violates personal beliefs.

WI **1996 Wis. Laws, Act 165 (AB 154)** exempts breast-feeding mothers from the law that makes exposure of sexual organs to a child a Class A misdemeanor.

WI **1996 Wis. Laws, Act 365 (AB 926)** provides that no person may circumcise, excise or clasp together with buckles or stitches the labia majora, labia minora, or clitoris of a female minor. The act does not apply if the circumcision, excision or stitching is performed by a physician and is necessary for the health of the female minor or is necessary to correct an anatomical abnormality. The act stipulates that custom, ritual, or consent by the female minor or by a parent may not be used as a defense to prosecution. Fines are set at $10,000 or imprisonment for not more than five years or both.

WI **1996 Wis. Laws, Act 375 (AB 622)** allows the court, in making an order of legal custody, to require a parent who is not granted legal custody of a child to provide to the court medical and medical history information that is known to the parent. If the court orders joint legal custody, the court may require each parent to provide this information. The act requires the court to keep all information confidential and release it only in certain circumstances.

WI **1996 Wis. Laws, Act 386 (SB 94)** removes foster care or treatment foster care workers from the list of people who are allowed to refer an infant to a physician for testing of the infant's bodily fluids for controlled substances due to the mother's use of controlled substances while she was pregnant with the infant. The act removes the requirement that the parent or guardian consent to such a test and adds the stipulation that, in order to test the infant, a physician must determine that the health of the infant may be adversely affected by the controlled substances. Finally, the act eliminates the termination of the testing program.

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AL **1996 Ala. Acts, H. Jt. Res. 69** creates a joint interim committee composed of three members of each house to study all facets concerning the acquisition, maintenance, allocation and structure of service delivery associated with federal block grants and major program reforms proposed by the United States president and Congress. The committee must report to the legislature by the 20th legislative day of the 1997 regular session, at which time the committee will be dissolved unless continued by a joint resolution.

AK **1996 Alaska Sess. Laws, Chap. 83 (HB 393)** directs the Department of Health and Social Services to implement at least two pilot projects to test the use of managed care in the state's Medicaid Program. The act allows the department to require Medicaid recipients in the project areas to participate in the projects in order to be eligible for Medicaid.

AZ **1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)** requires the director of the Arizona Health Care Cost Containment System (AHCCCS) to apply to the federal Health Care Financing Administration for authorization to reimburse services performed by eligible licensed midwives.

AZ **1996 Ariz. Sess. Laws, Chap. 288 (SB 1283)** changes the criterion for awarding contracts to managed care organizations under Medicaid from the "lowest qualified bids" to "proposals determined to be the most advantageous to the state."

Beginning October 1, 1997, the act establishes a three-year market competition pilot program for inpatient hospital reimbursement rates for urban health plans and program contractors. The act requires health plans and program contractors in Maricopa and Pima counties to contract and negotiate reimbursement rates with one or more hospitals in those counties. The act establishes default reimbursement rates for non-contracted inpatient hospital services in the two urban areas based on 95 percent of the rates in effect as of September 30, 1997. The act allows for an arbitration process in lieu of the grievance and appeals process to resolve contractual disputes. The act continues the ability to use AHCCCS fee-for-service rates or negotiate rates for health plans and program contractors in rural counties. AHCCCS, in consultation with hospital trade representatives and providers, is required to develop an implementation plan before beginning the market competition pilot program. The implementation plan must include a transition process to the new payment system and outcome criteria.

In addition, the act broadens the definition of a qualifying community health center and requires AHCCCS to develop rules and provide for a copayment by members for transportation (for example, ambulance service) in a non-emergency circumstance. The act requires AHCCCS, within three years from the effective date of the this act, in consultation with the hospital trade association and providers, to determine whether the inpatient hospital admissions and outpatient hospital services reimbursement methodology, as prescribed by law, should be modified. Finally, the act requires AHCCCS to recalculate the per diem payments to hospitals by October 1, 1998, and makes clarifying changes to the 1996 Health Omnibus Reconciliation bill.

AZ **1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)** changes the name of the medically needy and medically indigent program stabilization fund to the medical services stabilization fund. The act expands the use of money in the stabilization fund to be used to offset increases in the cost of providing levels of services to those eligible for Arizona Health Care Cost Containment System (AHCCCS) services through federal categories if the increase in costs is caused by a decrease in federal funding. The act makes a one-time transfer of $30 million from the medically needy account to the medical services stabilization fund.

Subject to the availability of funds in the medically needy account of the tobacco tax and health care fund, the act establishes the premium sharing demonstration project fund and the basic children's medical services program. The AHCCCS administration, contingent on the existence of the fund, is authorized to withdraw $20 million in FY 1996-97, 1997-98 and 1998-99 to be deposited in the fund to provide health care services to those eligible for the AHCCCS Premium Sharing Demonstration Project Implementation Committee to make recommendations to the governor, the legislature, the secretary of state and the director of the Arizona Legislative Council by November 15, 1996, regarding the implementation of a premium sharing program. The act recommends that the committee address participant eligibility criteria, an income threshold that does not exceed 300 percent of the federal poverty level, the types of services to be provided and the entity that should be responsible for collecting participant premiums. At the direction of the committee, the AHCCCS administration is required to conduct actuarial studies that provide rate and premium sharing cost estimates.

Beginning FY 1996-97 the act, annually transfers up to $5 million to the Department of Health Services (DHS) to establish contracts with eligible hospitals to provide for a basic children's medical services (BCMS) program, to provide health care services to indigent, uninsured or underinsured children who are not eligible for AHCCCS services. Up to two percent of the total funding is authorized to be used for administrative costs and additional money, as necessary, to perform program evaluations. Program money is required to be used to enhance the hospital's ability to provide additional services to eligible children and improve the delivery of inpatient, outpatient and specialized clinical services. The act sets out requirements for participating hospitals, including a sliding fee scale for eligible children. DHS is exempt from rule making requirements for the implementation of this program.

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. For most AHCCCS recipients, the federal government pays 65 percent and the state pays 35 percent of the costs of health care. Currently, there are many eligibility categories that determine whether an individual can receive health care under AHCCCS, including one that requires that a recipient's net income not exceed approximately 34 percent of the "federal poverty level." Proposition 203 expands eligibility to cover people who earn up to 100 percent of the federal poverty level under AHCCCS.

Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, to be allocated as follows: $5 million to the Healthy Families Program, which provides services to prevent child abuse and neglect and to promote child wellness and proper development; $4 million to the Arizona Health Education System to provide scholarships to medical students who agree to practice in areas of the state that are currently underserved by health care professionals; $3 million to programs to prevent teenage pregnancy; $2 million for disease control research; $2 million to Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children; and $1 million to the Women, Infants and Children Food Program.

Previously, lottery revenues were earmarked for deposit in economic development, local transportation assistance and two state heritage funds. Under Proposition 203, the $17 million will be distributed only after the economic development, local transportation assistance and heritage funds receive their full appropriations.

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CA **1996 Cal. Stats., Chap. 74 (AB 2804)** establishes a special supplemental payment to hospitals that provide a disproportionate share of care to Medi-Cal and other low income patients. The act limits the total amount of payment to $200 million with the stipulation that it could be less depending on the total amount of federal funds available for this purpose. The act provides that the nonfederal share of these supplemental payments would come from University of California hospitals through a special transfer provision.

CA **1996 Cal. Stats., Chap. 197 (AB 3483)** revises the eligibility requirements for Medi-Cal benefits for families who lose eligibility for Aid to Families with Dependent Children (AFDC) benefits due to the reuniting of separated spouses.

The act also excludes hospice benefits from the scope of Medi-Cal benefits through specified managed care programs.

In addition, the act revises the method of calculating the maximum allowable reimbursement rates for Medi-Cal drug treatment programs and requires the Department of Health Services to develop individual and group rates for extensive outpatient drug-free treatment counseling.

The act suspends, until January 1, 1999, the operative date for the establishment of a drug formulary and requires the Bureau of State Audits to prepare a report by January 1, 1998, on the drug program management techniques and the comparability of the program to other private sector third party payers. The act extends Medi-Cal's authority to contract for single-source and multi-source drugs until January 1, 1999 and extends the 10 percent supplemental rebate program to January 1, 1997.

The act revises the targeted care management county contribution requirements to the state and extends provisions in current law stating that certain aged, blind, or disabled persons are not responsible for "share of costs" for Medi-Cal benefits to reductions made during the 1996 portion of the 1995-96 regular session. Finally, the act establishes a state-only family planning program under Medi-Cal, for a period of three years to provide family planning services to all those with family incomes at or below 100 percent of the federal poverty level, who have no other health care coverage, except as described and are not otherwise eligible for Medi-Cal services without a share of the cost.

CA **1996 Cal. Stats., Chap. 198 (AB 3484)** reduces by $10 million the state fee paid by public hospitals participating in the disproportionate share hospital program.

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the operation and effective period of the perinatal services and perinatal outreach coordination and expansion services and the use of Proposition 99 funds for these services under the Medi-Cal Program.

CA **1996 Cal. Stats., Chap. 529 (SB 1636)** permits a hospital that meets the existing disproportionate share hospital criteria and is designated by the National Cancer Institute as a comprehensive/clinical cancer research facility to participate in the Emergency Services and Supplemental Payments Fund.

CA **1996 Cal. Stats., Chap. 534 (SB 1875)** requires HMOs to report summary information on the disposition of grievances or complaints, categorizing the information by whether the subscriber is covered under Medicare, Medi-Cal, or through private coverage, as specified.

CA **1996 Cal. Stats., Chap. 1099 (AB 1184)** increases payments in 1996-97 to disproportionate share hospitals under the Medi-Cal supplemental payments program. The increased payments are made to the extent that total payments do not exceed the $2.2 billion program cap after the initial round of payments, which are based on 80 percent of each hospital's past year Medi-Cal days.

CA **1996 Cal. Stats., Chap. 1114 (SB 1664)** authorizes the Department of Health Services to provide for mandatory enrollment of Medi-Cal-eligible people in a county-operated fee-for-service managed care pilot program in the counties of Sonoma, Placer and San Luis Obispo. The act requires boards of supervisors in participating counties to establish advisory committees to advise the counties on implementation and operation of the program and specifies other requirements.

CO **1996 Colo. Sess. Laws, Chap. 172 (HB 1188)** requires the state Department of Health Care Policy and Financing to ensure that managed care providers allow a recipient to disenroll at any time, implement consumer friendly procedures for disenrollment and allow adequate response time for recipients to make selection options. The act also provides that a person who is eligible for home- and community-based services for the developmentally disabled may be eligible for home- and community-based services for the elderly, blind and disabled if the need for such services is due to impairments based on developmental disability diagnosis.

CT **1996 Conn. Acts, P.A. 96-268 (SB 675)** requires the Department of Social Services' (DSS) commissioner to implement a managed care program for medical services provided under the state-administered General Assistance (GA) medical assistance program, beginning April 1, 1997. This program does not include substance abuse or mental health treatment provided by a program operated by the Department of Mental Health and Addiction Services (DMHAS) commissioner. The act permits DSS, beginning January 1, 1997, to award Medicaid managed care contracts on a competitive basis. The act also adds the Human Services Committee chairmen and ranking members to the Waiver Application Development Council, which is charged with advising DSS on the development of a Medicaid "1115" waiver.

FL **1996 Fla. Laws, Chap. 175 (SB 1662)** enacts the "Work and Gain Economic Self-Sufficiency (WAGES) Act" to implement welfare reform. Under the act, a family that meets the eligibility requirements for Medicaid assistance will receive medical services under the Medicaid program. The WAGES Program also ensures that a family that loses its temporary family assistance due to earnings shall remain eligible for Medicaid without reapplication during the succeeding 12-month period if private medical insurance is unavailable from the employer or is unaffordable. The family will be denied Medicaid during the 12-month period for any month in which the family does not include a dependent child. If the family's average gross monthly earnings during the preceding month exceed 185 percent of the federal poverty level, the family will be denied Medicaid. The family must be informed of transitional Medicaid when the family is notified of the termination of temporary assistance. The notice must include a description of the circumstances in which the transitional Medicaid may be terminated.

In addition, the act requires the Department of Health and Rehabilitative Services to create an error-prone or fraud-prone case profile within its public assistance information system and screen each application for public assistance, including food stamps, Medicaid and the WAGES Program, against the profile to identify cases that have a potential for error or fraud. The case identified will be subjected to pre-eligibility fraud screening. The act requires the Department of Health and Rehabilitative Services, or its designee, to enforce an order of income deduction by the court against the liable adult recipient or participant, including the head of a family, for overpayment received as an adult under the WAGES Program, the AFDC Program, the food stamp program, or the Medicaid program.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** strengthens the Agency for Health Care Administration's (AHCA) ability to regulate Medicaid HMOs in response to concerns about marketing and enrollment abuses, quality of care problems and reimbursement improprieties. The act prohibits managed care plans from enrolling Medicaid recipients. AHCA will perform choice counseling, enrollments and disenrollments of Medicaid recipients into managed care plans and MediPass. Managed care plans may perform supervised pre-enrollment and marketing functions. The act also prohibits door-to-door solicitation of Medicaid recipients, prohibits gift-giving and other inducements by all entities that contract to provide health services to Medicaid recipients and delineates mandatory managed care enrollment and assignment procedures.

The act authorizes a county public health unit or a county-operated managed care program to create a nonprofit corporation for the purpose of establishing an HMO with the approval of the board of county commissioners. The act authorizes the Agency of Health Care Administration

(AHCA) to contract with a prepaid limited health service organization for the Medicaid Program and sets conditions for participation in the program.

The act requires a health care quality improvement system for all providers with Medicaid contracts. AHCA must publish and make available to MediPass and fee-for-service patients, a toll-free telephone number to handle consumer complaints and maintain a statewide database of the complaints. The act requires AHCA to have a MediPass enrollee grievance procedure that is detailed in the handbook provided to enrollees. The grievance procedure must establish methods for classifying emergency, urgent and routine grievances and must establish standard time limits for resolving them. The act requires grievances that involve an emergency medical condition to be resolved within three hours after receipt. All others that involve urgent grievances must be resolved within two days after receipt. The act requires AHCA to conduct regular and ongoing Medicaid recipient-satisfaction surveys.

The act requires organizations with Medicaid contracts to annually review each primary care physician's load of active patients (who visit the doctor at least three times within a calendar year) and ensure that additional Medicaid recipients are not assigned to physicians who have a total active patient load of more than 3,000 patients.

The act establishes the Children's Medical Services alternative service network to serve children with special health care needs and children who participate in the Children's Medical Services Program. A qualified MediPass primary care provider from the Children's Medical Services network will serve as the gatekeeper and be responsible for providing or authorizing all health services to a child who has been assigned to the Children's Medical Services network by the Medicaid Program. Services provided through the Children's Medical Services network will be reimbursed on a fee-for-service basis and will utilize a primary care case management process. AHCA must approve requests to provide services to Medicaid-eligible children with special health care needs from managed care plans that meet quality of care and service integration standards and are in good standing with the agency. The act requires AHCA to monitor on a quarterly basis managed care plans that have been approved to provide services to Medicaid-eligible children with special health care needs. The act allows the Children's Medical Services network to contract with school districts participating in the certified school match program for the provision of school-based speech, occupational and physical therapy services for Medicaid-eligible children enrolled in the Children's Medical Services network.

In addition, the act authorizes a study of alternative service networks. Within existing resources, AHCA is directed to work with the Department of Insurance, the Department of Health and Rehabilitative Services, the Department of Education, the Department of Elderly Affairs and provider groups to study the feasibility of non-risk-bearing alternative service networks for Medicaid recipients. Possibly using the Children's Medical Services network as a model. An interim report is due to the governor and the chairpersons of the appropriations and health care committees of each chamber of the legislature by January 1, 1997 and a final report by January 1, 1998. Finally, the act requires the Department of Insurance (DOI) to establish actuarially sound medical loss ratios for Medicaid and details numerous licensure provisions relating to the DOI, including an increased fines for HMOs that violate DOI licensure requirements. (See "Medicaid" for a more detailed summary.)

FL **1996 Fla. Laws, Chap. 403 (HB 555)** establishes the Public Health and Health Care Administration Act of 1996. The act creates a new agency, the Department of Health (DOH) to serve as the single state agency responsible for all health matters for which the state has authority. The act transfers the Agency for Health Care Administration, the Agency for Public Health Services and the Division of Medical Quality Assurances to DOH. The act transfers the duties of the Department of Health and Rehabilitative Services, Children's Medical Services Program Office and the Alcohol, Drug Abuse and Mental Health Program Office to the Agency for Public Health Services.

GA **1996 Ga. Laws, p. 1037 (H 1265)** appropriates funds for Medicaid services. The act requires the department of Medical Assistance to exclude pharmacy services in the HMO pilot and allow acute

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care hospitals statewide to contract with Medicaid for services on a non-risk capitated rate. The act requires the department to implement a clinically based, automated prospective drug utilization review program and designates $100,000 for the independent care program for personal assistance and support.

HI **1996 Hawaii Sess. Laws, Act 68 (HB 3461)** appropriates $96 million in federal funds of the state of Hawaii to the Department of Human Services for the medical assistance program known as Hawaii QUEST and the Medicaid Program in anticipation of a new federal block grant. With this new federal block grant formula, the department needs to increase its federal ceiling in order to meet its fiscal obligation to provide health and health-related services to Hawaii QUEST and Medicaid recipients. Any unexpended or unencumbered balances of this appropriation will lapse into the appropriate fund at the close of business on June 30, 1996.

HI **1996 Hawaii Sess. Laws, Act 287 (HB 2800)** makes appropriations for health care payments, provided that a study be conducted on the various drug therapies used in the Med-QUEST Program. The study must include detailed clinical analysis of the health care benefits of various drug treatments and economic analysis of the health care savings of various drug treatments and an analysis of the quality and scope of various drug treatments which are currently prescribed, including more expensive treatments. The study also must include an examination of alternatives which will make additional funds available for the purchase of various drug therapies, provided that the study include drug treatments that vary from the current costs of the prescribed generic agents. The Department of Human Services must submit results of the study to the legislature no later than twenty days before the convening of the 1997 regular session.

The act also makes appropriations to the Department of Education, the Department of Human Services and the Department of Health, provided that the departments work together to develop working agreements regarding services provided to children through school-based health centers. These agencies are required to create an interdepartmental program for the development of pilot projects to demonstrate mental health, education and protective services to children and adolescents who are clients of more than one agency.

Finally, the act provides appropriations for developmental disabilities, provided that any amount in excess of the appropriation due to deinstitutionalization and savings for FY 1995-96 and FY 1996-97 may be used for purchase of services, matching funds for Medicaid community-based programs, or to establish small community intermediate care facilities for the mentally retarded. The act also provides that to ensure the continuing receipt of federal funding for the Hawaii Ohana Project in child and adolescent mental health, the Department of Health must work to expedite the execution of the grant.

ID **1996 Idaho Sess. Laws, Chap. 338 (H 533)** establishes that reimbursement for intermediate care facilities for the mentally retarded be based on a prospective rate system without retrospective settlement, effective October 1, 1996 and details components used to determine the rate.

IL **1996 Ill. Laws, P.A. 89-513 (HB 2557)** requires health and accident insurers providing maternity coverage to allow for a minimum of 48 hours of inpatient care for both mother and newborn following a vaginal delivery. For Cesarean deliveries, inpatient coverage must be provided for a minimum of 96 hours. A shorter inpatient stay may be allowed if the attending physician determines that a mother and newborn meet established guidelines for that shorter length of stay. In this case, there also must be coverage and availability for a post-discharge physician office visit or in-home nurse visit in the first 48 hours after discharge. People receiving medical assistance under the state Public Aid Code also must be provided with the same levels of coverage and care.

IL **1996 Ill. Laws, P.A. 89-517 (HB 3613)** allows the Department of Public Aid, in cooperation with the Departments of Alcoholism and Substance Abuse and Public Health, through a public awareness campaign, to provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

IN **1996 Ind. Acts, P.L. 108 (SB 175)** establishes the select joint committee to investigate Medicaid reimbursement to investigate and provide potential legislative and administrative solutions to problems regarding Medicaid reimbursement to providers. The committee must submit a full report to legislative and executive entities detailing problems associated with processing provider claims by December 1, 1996. The committee also must study development of a case mix reimbursement system for nursing facilities. The act also establishes a preadmission screening study committee to study the efficiency, effectiveness and necessity of the preadmission screening program; provides that the Medicaid drug utilization review program will be extended under any new federal law regarding Medicaid; and limits to 1,000 the number of participants residing in Marion County who may participate in any Medicaid demonstration project.

IN **1996 Ind. Acts, P.L. 114 (SB 414)** provides that when a Medicaid recipient does not make the required copayment, the Office of Medicaid Policy and Planning may not require a Medicaid provider to collect the copayment. The act also authorizes a licensed pharmacist to adjust a patient's drug regimen in a health care facility under certain circumstances.

IN **1996 Ind. Acts, P.L. 115 (HB 1252)** reduces the amounts certain hospitals transfer to the Medicaid indigent care trust fund. The act reduces the amounts paid to certain hospitals for enhanced disproportionate share adjustments and allows certain disproportionate share hospitals to have the hospital's utilization data certified by an independent certified public accounting firm.

IN **1996 Ind. Acts, P.L. 241 (HB 1219)** establishes the Select Joint Committee to investigate Medicaid reimbursement, which is required to investigate problems related to reimbursement of provider claims for payment. The act explains the concept of a Medigrant Program and provides that the Office of Medicaid Policy and Planning may not, before April 30, 1997, amend the Medicaid state plan in effect on December 31, 1995, except as necessary to comply with federal or state law regarding Medicaid. The office must submit to the committee a proposed Medigrant state plan that complies with the Medigrant Program and to receive written comments from the committee before submitting the proposed plan to the U.S. Department of Health and Human Services for approval. The act requires the committee to review federal legislation establishing the Medigrant Program and make recommendations to the General Assembly regarding the state's participation in and implementation of the Medigrant Program. The act requires the executive branch to submit any proposed elections to the committee before making an election that the state may have under the Medigrant Program to calculate the amount of funds given to the state by the federal government for the Medigrant Program. The committee must provide written recommendations to the executive branch regarding a proposed election within 60 days after receiving the information. If a federal block grant replaces any part of the Aid to Families with Dependent Children (AFDC) Program, the Division of Family and Children must comply with state law enacted during the 1995 session of the General Assembly regarding welfare reform to the extent permitted under federal law.

IN **1996 Ind. Acts, P.L. 246 (HB 1354)** requires the Office of Medicaid Policy and Planning to seek federal approval to allow Indiana to increase by at least 175, before July 1, 1996, the number of waiver slots for individuals using an intermediate care facility for the mentally retarded under a home- and community-based waiver. The act also requires the Office of the Secretary of Family and Social Services to prepare a report concerning individuals with developmental disabilities.

KS **1996 Kan. Sess. Laws, Chap. 96 (SB 573)** requires any health plan that provides coverage for maternity services, including benefits for childbirth, to provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by Cesarean section for a mother and her newborn child in a medical care facility. Any decision to shorten the length of inpatient stay must be made by the attending physician. No health plan may terminate the service or, penalize, or provide financial disincentives in response to any attending physician who orders care consistent with the provisions of this act.

Any health plan that provides coverage for postdelivery care to a mother and newborn child in the home is not required to provide coverage of the minimum lengths of inpatient care, unless it is determined to be medically necessary by the attending physician. The act requires all health plans to provide written notice, as currently required, to all enrollees, insureds, or subscribers regarding

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the coverage required by this act. Finally, the act specifies that no policy, agreement, contract or certificate issued by a corporation to which this act applies may contain a provision which excludes, limits, or otherwise restricts coverage because Medicaid benefits are or may be available for the same accident or sickness.

KS **1996 Kan. Sess. Laws, Chap. 130 (S 593)** relates to the right to coordinate benefits with a private carrier. When medical assistance is furnished or any other health care program funded by federal or state money to a person having private health care coverage, the Department of Social and Rehabilitation Services or any other state agency furnishing such medical assistance is entitled to be subrogated to the rights that the person has against the carrier of the coverage to the extent of health care services rendered. Such action may be brought within two years (previously three years) from the date that service was rendered.

KS **1996 Kan. Sess. Laws, Chap. 210 (SB 625)** allows a not-for-profit corporation that is also a medical care facility, an indigent health care clinic, a federally qualified health center, or a local health department to enter into a contract or to employ a licensed dentist to provide dental services to people who are indigent and do not have health insurance, people who are eligible for Medicaid, or people who are qualified for Indian Health Services. A dentist who provides services for the dentally indigent is immune from liability. The act also provides that a dentist who is classified as retired by the board is not required to pay an annual license renewal fee or meet continuing education requirements if the dentist elects to provide dental services to the dentally indigent through one of the entities set out in this act. The provisions of the act expire on July 1, 1998.

KY **1996 Ky. Acts, Chap. 304 (HB 494)** permits the Cabinet to make payments under the Medical Assistance Program for services which are within the lawful scope of practice of a chiropractor to the extent the Medical Assistance Program pays for the same services provided by a physician.

KY **1996 Ky. Acts, Chap. 353 (SB 49)** amends existing law relating to health insurance plans, including HMOs, to require patients and health care providers to be notified of their right to appeal adverse determinations of private review agents to reduce or deny payment of health benefits. The act requires all insurance companies to provide, upon request from the Cabinet for Human Resources, information on Medicaid-eligible policyholders and dependents to be used to determine the availability of other medical benefits in order to ascertain that Medicaid is the payer of last resort.

KY **1996 Ky. Acts, Chap. 371 (SB 343)** makes numerous changes to the comprehensive health reform legislation enacted in 1994. The act deletes the requirement that the Cabinet for Human Resources seek a federal waiver to require Medicaid recipients to pay $3 copayments on specified services; deletes the previous mandatory participation for non-institutionalized aged, blind and disabled recipients in Medicaid Managed Care; repeals the discount option program, which permitted low-income people to buy health care services at Medicaid rates; and prohibits Medicaid payment for services provided in Kentucky by an out-of-state health facility or services if the facility or services do not have a certificate of need (CON) and would otherwise be required to obtain a CON if located in Kentucky. (See "Access and Reform" for a more detailed summary of this act.)

LA **1996 La. Acts, H. Concur. Res. 42** requests the secretary of the Department of Health and Hospitals (DHH), in budget recommendations and DHH budget actions, to refrain from cutting any funding designated for people with mental retardation and developmental disabilities (MR/DD) and to refrain from cutting waiver slots provided for MR/DD-eligible recipients, but to seek to increase the services provided under such waiver provisions.

ME **1996 Maine Laws, Chap. 653 (LD 1759)** appropriates funds for several health and human services' programs and requires that pharmacies pay a 25 cent per prescription processing service fee on every Medicaid prescription to be deposited into the Medical Care-Payments to Providers Special Revenue account.

ME **1996 Maine Laws, Chap. 675 (LD 271)** authorizes the Department of Human Services to establish an electronic benefit transfer (EBT) system to issue all benefits under the Aid to Families with Dependent Children (AFDC), food stamp and Medicaid programs. The act allows the department to add other programs to the EBT system if approved for addition by their respective departments, as long as rules are adopted by the department and other departments for the administration of and delivery of benefits under those programs.

ME **1996 Maine Laws, Chap. 692 (LD 1812)** provides transitional eligibility for medical assistance to parents leaving the Aid to Families with Dependent Children Program (AFDC) whose average gross monthly earnings, minus costs for any child care necessary for employment, do not exceed 185 percent of the federal poverty guidelines. A family entering the transitional medical assistance program before February 1, 1997, with income above 133 percent of the federal poverty guidelines must pay premiums in accordance with rules adopted by the department. Rules adopted pursuant to this subsection are routine technical rules as defined by Title V, chapter 375, subchapter II-A. A family whose average gross monthly earnings are above 100 percent of the federal poverty guidelines, must pay, beginning in their seventh month of receiving transitional medical assistance, monthly premiums equal to 3 percent of their average gross monthly earnings, less the average monthly costs for any child care necessary for employment. The department must extend the transitional medical assistance program to families who meet the requirements of the program and who enter the program on or after February 1, 1997, for two years beyond the families initial one-year period of eligibility.

MD **1996 Md. Laws, Chap. 102 (SB 104)** repeals the publication requirement and allows the medical assistance program to pay for a generic drug as soon as it is added to the state formulary.

MD **1996 Md. Laws, Chap. 352 (SB 750)** authorizes the state to submit a section 1115 Medicaid waiver proposal to the federal Health Care Financing Administration (HCFA) and specifies that its provisions must include authorizing the Department of Health and Mental Hygiene to require program recipients to enroll in managed care organizations, to prohibit managed care organizations from enrolling program recipients and to require managed care organizations to include providers who have historically served program recipients. The act defines certain terms and includes provisions relating to eligibility and managed care organizations under the Maryland Medical Assistance Program.

The secretary of health and mental hygiene must establish a long-term managed care advisory committee to advise on development of a managed care proposal for the Medicaid long-term population. By January 1, 1997, the secretary must present to the governor and the general assembly a managed care proposal for the Medicaid long-term care population.

The act requires managed care organizations that are not certified HMOs to meet solvency standards similar to those for HMOs, but allows the insurance commissioner to adjust the standards under certain circumstances. The act also specifies that managed care organizations are responsible for providing primary mental health services under the program. Specialty mental health services will be provided either by a delivery system run by the Mental Hygiene Administration or by managed care organizations that meet certain quality standards and contract with the Mental Hygiene Administration to provide those services.

The Health Resources Planning Commission, in consultation with the department and the Health Services Cost Review Commission, must study the existing impact on existing community health centers and other primary care providers of the laws, regulations, the grant of federal waiver and other governmental actions that authorize or require the enrollment of Maryland Medical Assistance Program recipients into managed care plans or organizations. The study must include an assessment of the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The study also must include an examination of the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. The commission must submit a report on the results of its investigation and study, together with any resulting policy recommendations, to the governor, the secretary of health and mental hygiene and the general assembly on or before November 1, 1996.

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MD **1996 Md. Laws, Chap. 352 and 102 (SB 750/SB 104)** authorizes the Department of Health and Mental Hygiene to provide guaranteed eligibility in the Maryland Medical Assistance Program for a certain period under certain circumstances. The act authorizes the department to require Medicaid recipients to enroll in managed care organizations and establishes certain solvency requirements for managed care organizations. The act also requires the department to establish a mechanism for providers who have historically served program recipients to remain providers under Medicaid managed care.

MD **1996 Md. Laws, Chap. 549 (HB 1390)** requires the Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review Commission, to assess the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The act also directs the commission to examine the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. A report on the results of the commission's investigation, together with any resulting policy recommendations, is due on or before November 1, 1996.

MA **1996 Mass. Acts, Chap. 203 (HB 6107)** expands Medicaid eligibility for children under age 12 with family incomes under 200 percent of poverty. The act authorizes Medicaid benefits to be provided by means of a demonstration project known as MassHealth. The act also expands eligibility for the Children's Medical Security Plan to children from the current age 12 to 18, which covers Medicaid ineligible children on a sliding scale basis.

The act increases the cigarette tax to 25 cents per pack, which also applies to cigars and pipe tobacco, to help fund both program expansions.

The act also establishes a program of pharmacy assistance for certain people with disabilities and elderly people who are not eligible for medical assistance or other third-party coverage for pharmacy benefits.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following: the department must ensure that all eligible children assigned to medical services managed care programs have timely access to early and periodic screening, diagnosis, and treatment (EPSDT) services as required by federal law.

The department may require medical services recipients to receive psychiatric services through a managed care system and must continue to implement managed care and require medical services recipients residing in counties offering managed care options to choose the particular managed care plan in which they wish to be enrolled. Those not expressing a preference shall be assigned to a managed care provider. The department must obtain from those HMOs and clinic plans with which the department contracts patient-based utilization data, including immunizations, early and periodic screenings, diagnoses, and treatments, substance abuse services, and maternal and infant support services referrals.

The act enables the department to increase enrollment of Medicaid-eligible persons in capitated health plans during fiscal year 1996-97. Mandatory enrollment may occur for the elderly, the disabled, the medically needy, individuals with mental illness, individuals who have a developmental disability, children with serious emotional disturbance, and recipients of children's special health care services if both of the following conditions are met: continuity of care is assured by allowing enrollees to continue receiving currently required medically necessary services from their primary providers for a period not to exceed a year; and a contract for an independent evaluation is in place to measure cost, access, quality and patient satisfaction. The department must provide a report on the progress of the Medicaid managed mental health care program to the legislature by September 30, 1997. This report shall summarize actions taken by the department and community mental health services programs to implement the managed mental health care program and include summary information on inpatient and partial hospitalization and costs, access to services, and summary information on consumer satisfaction measures. The act authorizes the department to develop a program for providing services to medical assistance recipients under a full-risk capitation arrangement, through contracts with provider-sponsored networks, health maintenance organizations, and other organizations.

The department must establish uniform quality and reporting standards for all capitated health plans with which it contracts. At least 30 days prior to the implementation of such standards, the department shall report on the standards developed to the House and Senate appropriations subcommittees on community health and fiscal agencies. The act also specifies many other quality control requirements for Medicaid capitated health plans. The act prohibits such plans from directly marketing their services to or enrolling Medicaid-eligible persons. The department must provide or arrange for assistance to Medicaid enrollees in understanding, electing, and using the managed care plans available. Information regarding the available health plans and enrollment materials must be provided through local Family Independence Agency offices during the eligibility determination and redetermination process, and at other locations specified by the department. The department must contract for enrollee services with local health departments or other community-based organizations in geographic areas where capitated health plans are serving Medicaid recipients, but such organizations may not be involved in the delivery of Medicaid capitated health plan services. Enrollee services must help Medicaid recipients make an informed choice regarding plan enrollment, assist with enrollee satisfaction and access surveys, and access appropriate complaint and grievance systems. The department shall make the results of enrollee satisfaction and access surveys available to the legislature and the public.

The act specifies that the mother of an unborn child must be eligible for medical services benefits for herself and her child if all other eligibility factors are met. To be eligible for these benefits, the applicant must provide medical evidence of her pregnancy, or if she is unable to provide the documentation, payment for the examination may be at state expense. The Department Community Health must undertake such measures as may be necessary to ensure that necessary prenatal care is provided to medical services eligible recipients. The department may only contract with health plans which cover a minimum length of postpartum stay at a hospital that is consistent with the minimum postpartum hospital stay standards of the American Academy of Pediatrics and American College of Obstetrics and Gynecologists.

The act also authorizes the department to pursue reimbursement for eligible services provided in Michigan schools from the federal Medicaid program. The department must require copayments on dental, podiatric, chiropractic, vision, and hearing aid services provided to recipients of medical assistance, except as excluded by law and allows the copayments to be waived for recipients who participate in a program of medical case management such as enrollment in an HMO or the primary physician sponsor plan program. In cooperation with other appropriate departments, the department must initiate a pilot project for the use of Medicaid program eligibility cards which simplify eligibility verification and assist in tracking and controlling Medicaid utilization.

In cooperation with the Family Independence Agency, the department may establish a pilot project for those who work their way off welfare to purchase Medicaid coverage at a rate determined by the department. The department may receive and expend premiums for the buy-in of Medicaid coverage in addition to the amounts appropriated in this act.

MN **1996 Minn. Laws, Chap. 440 (SF 2410)** specifies that provider organizations and individual health care providers are to use the first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration (HCFA) as their unique provider number. Provider organizations required to obtain a national provider identifier from HCFA include hospitals, nursing homes and hospices, subacute care facilities, individual providers organized as a clinic or group practice, independent laboratory, ambulance services and special transportation services. Individual providers required to have a national provider identifier include physicians, dentists, chiropractors, podiatrists, physician assistants, advanced practice nurses, doctors of optometry, individual providers who may bill Medicare for medical and other health services and individual providers who are providers for state and federal health care programs administered by the commissioner of human services. The act specifies that the payer identification number assigned for the federal HCFA's PAYREID system will be used as the unique identification number for group purchasers. The act also requires group purchasers to obtain a payer ID number from HCFA.

The act establishes procedures for disclosing certain non-public data to related group purchasers. The act authorizes the commissioner to publish, or release to the public by other means, the named identity of a group purchaser as part of an analysis of information collected from the birth registration. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data, the commissioner must include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. The provision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** delays from July 1, 1995, to October 31, 1997, the date that all managed care organizations must file biennial action plans describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. The act requires the commissioner to report on recommendations to the Legislature by January 15, 1997, identifying county social services and public health administrative costs for each target population that should be excluded from the overall capitation rate. The act requires the commissioner of human services to study and report to the Legislature by January 1, 1997, on the advisability of compensating clients in the public health care programs if a client has successfully reversed a private insurer's denial of health insurance.

The report also must include recommendations on reducing the parental fees under current statutes if a parent has successfully reversed a private insurer's denial of insurance. The act requires integrated service networks (ISNs), as a condition of licensure to participate in the medical assistance, general assistance medical care and MinnesotaCare programs. ISNs, which function as both health care provider and insurer are required to submit proposals in good faith to service people who are eligible for these programs if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the ISN is less than the ISNs percentage of the total number of individuals enrolled in ISNs in the same region. Geographic regions will be defined by the commissioner of human services in the request for proposals. The act requires the commissioner to seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner is directed to develop an increase of up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. before implementation, the commissioner must submit this fee schedule to the chair and ranking minority member of specified legislative committees. The act allows the commissioner to assign an individual with private coverage through an HMO to the same HMO for medical assistance coverage, if the HMO is under contract for medical assistance in the individual's county of residence. The act allows Dakota county to implement a demonstration project to develop an enhanced automation system to educate public assistance recipients on their health care options. The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval and issuance of the request for proposals to provide services to eligible individuals within the proposed county.

The act requires the commissioner to develop consumer information systems and make informed choices about service delivery.

The act clarifies that a medical assistance recipient may receive an initial assessment and up to two reassessments per year done to determine a recipient's need for personal care services. In the case of children with disabilities or mental illness, after a child is determines to be eligible for medical assistance, the commissioner must review the child's disability and level of care no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years.

The act provides that personal care services may not be reimbursed by Medicaid if the personal care assistant is the spouse or legal guardian of the recipient or the parent of a recipient under age 18. Foster care providers of recipients who cannot direct their own care may be reimbursed as a personal care assistant only if a county or state case manager visits the recipient at least every six months to monitor the health and safety of the recipients and to ensure the goals of the care plan are met.

The act appropriates $5 million for nursing homes and attaches a 30-day residency requirement for people who apply for Aid to Families with Dependent Children, medical assistance, general assistance, or general assistance medical care. The act restores $4.7 million in cuts made by 1995 Legislature to a program that helps people with disabilities live independently at home instead of in a group home or nursing home. Changes in the program, which provides in-home personal care attendants (PCA) for the disabled, required those receiving the help of a PCA to be capable of directing their own care or be cared for by family members or placed in an institution. Another change reduced by 12.5 percent the maximum number of personal care service hours a recipient could receive. The 1995 law also cut "prompting" and "monitoring" services that meant in which a PCA reminded clients to take medication, prepared meals, or helped get clients to and from medical appointments. The new act restores those cuts, eliminates the requirement that recipients be able to direct their own care and reinstates services such as prompting and monitoring.

The act requires the commissioner of human services to utilize staff in the families with children service division, the long-term care home- and community-based services division, the division for those with developmental disabilities and the quality services division to examine and report on strategies for supporting families with medically fragile and technology-dependent children. the study must report on the coordination and administration of medical assistance services, including services through the home- and community-based waiver programs, with respect to the out-of-home placement of medically fragile and technology-dependent children. The study also must examine and recommend strategies for decreasing the number of these children who are hospitalized, or whose length of stay in a hospital is extended because appropriate foster care placements are not available or not affordable under the current reimbursement system for the medical assistance waiver programs. The commissioner must submit the report to the Legislature by January 15, 1997.

The act amends the criteria for the essential community provider designation to include a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems and other disabling conditions.

The act requires the commissioner of human services to review the administration of the community alternative care home- and community-based waiver program and evaluate the extent to which the program is administered in a consistent manner throughout the state. The commissioner also must study and make recommendations about changing the community alternative care waiver program to a regionally administered program, following the model of the traumatic brain injury waiver program and report to the Legislature by February 1, 1997. (See "Special Health Care Needs" for more information.)

The act allows the commissioner to make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner is not dependent upon county agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance program and for covered services.

MS **1996 Miss. Laws, Chap. 496 (H 1187)** amends current law to specify that all University of Mississippi Medical Center locations provide not less than 50 percent of their services to indigent people, including qualified beneficiaries of the state Medicaid Program. The act also authorizes the teaching hospital and related facilities to establish and operate managed care plans and to enter into group purchasing arrangements.

MS **1996 Miss. Laws, Chap. 518 (S 2759)** allows the Division of Medicaid to examine Medicaid reimbursement methodologies for home health services and to develop its own cost report in order to contain costs. The division also may revise methodologies involved in the case-mix payment system in order to reduce or end current incentives in the reimbursement formula for nursing facilities to transfer their patients to hospitals.

In addition, the act directs the division to develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings. In no case may the total payment exceed twice the amount of the dispensing fee.

MS **1996 Miss. Laws, H. Concur. Res. 198** creates a joint study and oversight committee to study and make recommendations concerning the implementation of capitated managed care for Medicaid recipients in Mississippi and to monitor the capitated managed care pilot program implemented by the Division of Medicaid.

NE **1996 Neb. Laws, L.B. 1155** adopts the False Medicaid Claims Act, providing the state with authority to file a civil action against a person who makes a false claim and to collect damages and investigation costs.

NH **1996 N.H. Laws, Chap. 123 (HB 1522)** establishes a committee to review the rate setting methodology used by the Department of Health and Human Services for establishment of Medicaid reimbursement rates for home health care services and to make suggestions for legislative requirements relating to such rate setting process. Home health care services include those services delivered by home health agencies, but not services delivered under the home- and community-based care developmental disability program.

NJ **1996 N.J. Laws, Chap. 42 (SB 3)** provides that each local school district that participates in the Special Education Medicaid Initiative shall receive a percentage of the federal revenue the district's participation yields for current year claims. The percentage share for local school districts shall be 15 percent of the first $53 million of federal reimbursements realized. After federal reimbursements are realized in excess of $53 million, local school districts shall receive a percentage of such revenue based on the level of participation they achieve.

NM **1996 N.M. Laws, Chap. 70 (SB 124)** amends a section of the Public Assistance Act related to Medicaid reimbursement to allow entities that contract with the Human Services Department under the Medicaid managed care program to negotiate reimbursement rates with providers. The act is designed to encourage providers to participate in the Medicaid managed care program at more equitable negotiated rates to increase access to care for Medicaid recipients.

NM **1996 N.M. Laws, H. Jt. Mem. 8** requests the Human Services Department to report on provider rate fee increases and other options to ensure adequate service of Medicaid patients throughout the state.

NM **1996 N.M. Laws, Sen. Jt. Mem. 28** directs the Social Services Department and agencies to include consumers and providers in decision-making on block grant distribution and managed care.

NM **1996 N.M. Laws, Sen. Jt. Mem. 32** requests that the human services department include expanded emergency medical services for reimbursement under Medicaid or its successor program.

NM **1996 N.M. Laws, Sen. Jt. Mem. 50** requests that the Human Services Department, in consultation with other state agencies using Medicaid funds, conduct a review that considers the full array of services and medical benefits provided in the Medicaid Program and the allocation of state and federal funds for the program. The memorial requests that a broad-based public process be used to develop a consensus on values to guide Medicaid spending and Medicaid resource allocation, taking into consideration all Medicaid services including nursing facilities and institutional and home- and community-based care for people with developmental disabilities, chronic mental illness, emotional disturbance or dependence on alcohol or drugs. The public review process must include a series of public hearings and seek testimony and information from a wide range of interested persons, including legislative and executive representatives; advocates for senior citizens, people with disabilities, mental health consumers, low-income individuals, Medicaid recipients and providers or potential providers of services for the Medicaid Program.

NY **1996 N.Y. Laws, Chap. 47 (5756-A)** restores full Medicaid fee-for-service reimbursement for physician services delivered in a hospital emergency room or outpatient department retroactive to July 1, 1995. Previous law required that the costs for such services be paid out of the hospital's Medicaid operating cost component rate, but a temporary restraining order issued in U.S. District Court has made the law untenable.

NY **1996 N.Y. Laws, Chap. 350 (S 7650-A)** extends the expiration date of the Medicaid Physician Case Management and Prepaid Health Service Programs for an additional year, until July 1, 1997.

NY **1996 N.Y. Laws, Chap. 526 (S 6615-A)** extends, until December 31, 1997, Medicaid eligibility for certain enrollees in comprehensive health care organizations who have lost Medicaid eligibility and disabled children in care-at-home programs.

NY **1996 N.Y. Laws, Chap. 649 (A 11329)** extends the statutory authority for the state's Medicaid Managed Care Program for four additional years, to July 1, 2000, in order to continue existing managed care programs. The act transfers primary responsibility for the program from the Department of Social Services to the Department of Health (DOH). The act specifies Medicaid recipients who are and are not mandated to participate in managed care, making allowances for people with special health care needs and situations such as geographic proximity to managed care providers. Mandatory enrollment in managed care may be deferred for pregnant women who have an established relationship with a comprehensive prenatal care provider that is not associated with a managed care provider in the program. The act provides a limited extension of benefits for certain pregnant women who lose Medicaid eligibility due to income in excess of the established medically needy income level. The act authorizes the commissioner of health to provide services on a capitated basis to people with HIV infection and to people with mental illness.

The act imposes marketing and enrollment guidelines to prevent door-to-door solicitation at the homes of Medicaid recipients and also prohibits telephone "cold calling" to solicit enrollment. The act directs the commissioner to institute a comprehensive quality assurance system for managed care providers that includes performance and outcome-based quality standards for managed care.

The act abolishes the Managed Medical Care Demonstration Program Advisory Council and establishes the Special Advisory Review Panel on Medicaid Managed Care. The panel is directed to determine whether there is sufficient provider participation in the program; whether a sufficient number of recipients choose their own managed care plan (as opposed to being assigned a plan); evaluate the adequacy of managed care provider capacity; examine the cost implications of populations excluded and exempted from Medicaid managed care; and to examine other issues.

NC **1996 N.C. Sess. Laws, Extra Sess., Chaps. 17 and 18 (HB 53 and SB 46)** continue the Medicaid Task Force and require it to report to the 1997 General Assembly.

NC **1996 N.C. Sess. Laws, Second Extra Sess., Chap. 18 (HB 53, Sec. 24)** adds new provisions authorizing the Division of Medical Assistance to 1) provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing state savings with counties responsible for the recovery of such funds; 2) use federal funds that are identified to support the cost of development and acquisition of equipment and software through contractual means to improve and enhance information systems that provide management information and claims processing; 3) adopt temporary rules to administer Medicaid estate recovery as mandated by the Omnibus Budget

Reconciliation Act of 1993; 4) adopt temporary rules if necessary to maximize receipt of federal funds, to reduce Medicaid expenditures and to reduce fraud and abuse; and 5) to allow Medicaid payments for physical therapy and speech therapy to be made to qualified providers of such services rather than only to the Children's Special Health Services Program.

OH **1996 Ohio Laws, H. 710** requires the Ohio Department of Human Services (ODHS) to adopt rules implementing the terms and conditions of the state's federal welfare reform waiver. The act provides that an assistance group that would be eligible for Aid to Dependent Children (ADC) if not for certain sanctions is eligible for Medicaid, including the member who caused the sanction. The act changes the sanction for a fourth or subsequent violation concerning JOBS, Medicaid substance abuse assessment and treatment and ADC immunization requirements.

OH **1996 Ohio Laws, S. 199** requires health care policies that cover maternity benefits and the state Medicaid program to cover for a mother and her newborn child a minimum of 48 hours of inpatient care for a normal vaginal delivery, a minimum of 96 hours of inpatient care for a Cesarean delivery and a minimum amount of follow-up care. The act specifies that any decision regarding early discharge of a mother or newborn is the responsibility of the attending physician or nurse-midwife after consulting with the mother. The act also requires the Public Health Council to include in its rules prescribing laboratory tests to detect phenylketonuria in newborns any test that it determines is effective to detect the disorder in newborns younger than 48 hours old.

OK **1996 Okla. Sess. Laws, Chap. 321 (HB 2497)** postpones until July 1, 1997, the expansion of the Medicaid managed care system to include all AFDC and medically needy participants, due to difficulties in establishing the necessary primary care networks.

OR **Measure 44, 1996 General Election (ballot initiative)** increases the state's cigarette tax from 1.4 to 2.9 cents per cigarette, with the majority of the tax going to the Oregon Health Plan for tobacco use reduction programs. The measure adds one-time taxes totaling 3 cents per cigarette, with proceeds going to the Oregon Health Plan tobacco use reduction. The measure also retains a .5 cent per cigarette tax that funds the Oregon Health Plan, to maintain and expand the number of people eligible for medical assistance.

PA **1996 Pa. Laws, Act 35 (SB 1441)** concerns welfare reform and requires recipients of general assistance medical-related medical assistance to pay a $150 deductible each fiscal year for medical assistance-compensable ambulatory surgical center services, inpatient hospital services or outpatient hospital services, excluding laboratory and x-ray services.

The act requires any managed care entity under contract to the Department of Public Welfare to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance Program that is willing to comply with the managed care entity's pharmacy payment rates and terms and to adhere to quality standards established by the managed care entity.

RI **1996 R.I. Pub. Laws, Chap. 100 (HB 8783)** authorizes the Department of Human Services to amend its regulations and fee schedules and the Rhode Island State Plan for Medical Assistance (Medicaid) to limit reimbursement to in-state and out-of-state hospitals for inpatient services provided to eligible persons in accordance with this act. Inpatient hospital services reimbursement is limited to $75,000 per admission, except for organ transplant admissions. The act establishes the rates of reimbursement to hospitals for outpatient services to eligible recipients equal to 60 percent of the hospital's ratio of costs to charge such services. The act increases RIte Care transition payments to community health centers from $10 to $15 per member per month and designates that payment be made through Rhode Island Health Center Association Inc.

The act addresses uncompensated care and the reimbursement hospitals are eligible to receive for treating patients without coverage. The act states that preservation of the ability of the private acute care hospital system of the state to continue to support an increasing uncompensated care burden is of critical importance to the public health and welfare of the citizens of Rhode Island and that implementation of the section of the Social Security Act that permits the federal government to share

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in the provision of payments to hospitals that provide a significant amount of uncompensated care is an effective way for the state to assist hospitals in continuing to provide uncompensated care.

Finally, the act creates within the Department of Elderly Affairs the Citizens Commission for the Safety and Care of the Elderly and enumerates its responsibilities, duties and functions.

RI **1996 R.I. Pub. Laws, Chaps. 129, 131 and 133 (SB 2377/SB 2725/HB 8603)** authorize the Department of Human Services to submit to the Department of Health and Human Services an amendment to the "RIte Care" waiver project to provide for expanded Medicaid coverage and children until they reach 18 years of age (formerly eight years of age), whose family income levels are up to 250 percent of the federal poverty level. Expansion of the RIte Track Program is subject to federal approval.

RI **1996 R.I. Pub. Laws, Sen. Res. 87** resolves that the Senate of the state of Rhode Island and Providence Plantation request the attorney general to initiate action against tobacco companies that would result in reimbursement to the state for the costs incurred by the Medicaid program for expenses related to the prevalence of smoking among the Medicaid population, which will not only lead to health care cost savings, but also may improve the quality of life of Rhode Island's citizen.

SC **1996 S.C. Acts, Act 452 (H 4789)** requires the state, subject to federal waiver, to provide transitional Medicaid and child care for a maximum of two years for Aid to Families with Dependent Children (AFDC) clients who lose eligibility because of employment or who become employed after losing eligibility as a result of exceeding the 24-month time limit. For individuals who become employed after a period of ineligibility due to exceeding the 24-month time limit, earnings must be less than poverty and continued employment must be jeopardized by medical expenditures to be eligible for transitional Medicaid and child care in the second year.

TN **1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)** directs the legislative oversight committee on TennCare to conduct an independent study of the TennCare pharmacy program that looks at grievance procedures, a monitoring process to ensure prompt reimbursement without disrupting patient care, disclosure measures to ensure patients are informed about the scope of the pharmaceutical benefit, ways to ensure the scientific and clinical integrity of health care decisions affecting TennCare enrollees and safeguards to preserve a competitive marketplace and the continuation of critical medical research and development.

The act authorizes the TennCare Bureau, the TennCare Pharmacy Board and the Department of Finance and Administration to provide necessary assistance to the oversight committee in conducting its study. The oversight committee is authorized to invite TennCare managed care organizations, TennCare providers, pharmacists, pharmaceutical manufacturers and voluntary health associations to participate in the study. The oversight committee must report its findings and recommendations no later than January 10, 1997, to legislative health committee chairs and the Special Joint Committee to study women's health. The TennCare Bureau must file a report, at least annually, setting forth data and statistics relative to health care provided to women.

The act directs the TennCare Bureau and the Tennessee Department of Health to develop data measures to assess the effectiveness of presumptive eligibility, the distribution of providers for each managed care organization for TennCare enrollees within each health region and the incidences of early prenatal care for TennCare recipients. The managed care organizations are required to report regularly to the TennCare Bureau using the data measures developed.

UT **1996 Utah Laws, Chap. 108 (HB 129)** creates a Medicaid restricted account and states that any general funds appropriated to the Department of Health for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and are not otherwise designated as nonlapsing will lapse into the Medicaid restricted account. The act allows the legislature to appropriate money in the restricted account to fund programs that expand medical assistance coverage and private insurance plans to low-income persons who have not traditionally been serviced by Medicaid.

UT **1996 Utah Laws, Chap. 250 (SB 111)** amends the state's Medicaid freedom of choice waiver to allow contracts with private insurers, including HMOs and other private health care delivery organizations. The act specifies that, to the extent permissible under the waiver, the plan should utilize private insurance plans and provides that the Division of Health Care Financing is not prevented from contracting with a health care delivery organization that is not financially at risk if the division determines that it is advantageous to do so.

UT **1996 Utah Laws, Chap. 332 (SB 225)** requires family support services and associated case management services offered by the Division of Services for People with Disabilities be provided through vouchers or direct financial assistance. A voucher describes the services and supports that may be received and lists approved providers that may be used by a person with a disability or his parent or guardian to purchase services and supports. The voucher also includes a maximum dollar value, states the period of time within which the voucher must be used and is redeemable by an approved provider for payment by the division up to the dollar value of the voucher. The division must conduct an evaluation of the effects of providing vouchers and direct financial assistance under this act and report the results to the Human Services Interim Committee before December 31, 1998. To implement this act with regard to Medicaid funds, the Division of Health Care Financing within the Department of Health, in cooperation with the Division of Services for People with Disabilities is directed to submit an amendment to the state's Medicaid home- and community-based services waiver.

VT **1996 Vt. Acts, Act 152 (H 282)** provides for a process for recovering medical payments made by Medicaid from a third party. The act states that Medicaid is the payer of last resort; that Medicaid pays only after payment is made by any and all third parties, including Medicare, health insurance, medical coverage provided in conjunction with other compensation programs, such as worker's compensation, support settlements trust funds or any party determined to be liable in a negligence action that results in an agreement or judgment.

VA **1996 Va. Acts, Chap. 193 (HB 915)** requires the Department of Medical Assistance Services, in cooperation with the Department of Planning and Budget, to prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Education and Health.

VA **1996 Va. Acts, Chap. 318 (HB 617)** requires program information documents furnished to Medicaid recipients covered under Medicaid managed care plans to be written in non-technical, readily understandable language, using words of common, everyday usage. These documents (including forms, handbooks and brochures) are required to be analyzed under the Flesch Readability Formula and achieve a readability score or 40 or better. All such documents must be filed with the Department of Medical Assistance Services in advance of their use and distribution to program recipients and potential recipients, accompanied by certificates setting forth the documents Flesch scores and certifying compliance with the requirements of this law. Language mandated by federal or state laws, regulations or agencies is exempt from this requirement, but the mandate allowing the exemption must be documented.

VA **1996 Va. Acts, Chap. 511 (HB 1278)** allows the Board of Medical Assistance Services to approve other entities to determine eligibility for medical assistance in addition to local departments of social services.

VA **1996 Va. Acts, Chap. 864 (HB 1440)** requires the Department of Medical Assistance Services, in cooperation with the Department of Education, to examine the funding and components of the pilot school/community health centers. The Department may revise these programs. Any revisions must be designed to maximize access to health care for poor children and to improve the funding by making use of every possible, cost-effective means, Medicaid reimbursement or program. Any revisions also must be focused on prevention of large costs for acute or medical care and will include such concerns as: funding sources and means of distribution of the state match; benefits and drawbacks of allowing school divisions to provide services to disabled students as Medicaid providers in cooperation with their primary care physicians; the appropriate credentials of the providers of care in the school health centers; utilization of the Individualized Education Plan (IEP), when signed by a physician, as the plan of care; delivery of medically necessary services; and payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT); and the role of Medallion and Options programs in regard to the school health centers. Any funds necessary to support revisions to the school/community health center projects must be included in the budget estimates for the departments, as appropriate, for the next biennial budget.

VA **1996 Va. Acts, Chap. 946 (SB 492)** provides for the direct payment of licensed clinical social workers and licensed professional counselors who provide services reimbursable by Medicaid.

WI **1996 Wis. Laws, Act 164 (AB 666)** requires the Department of Health and Social Services to submit to the federal Department of Health and Human Services an amendment to the state medical assistance plan to receive federal financial participation for removable prosthodontic services (e.g., dentures and bridges), beginning on the earliest date permitted under federal law. The act also requires the department to pay a provider for removable and fixed prosthodontic services performed between October 1, 1995 and the effective date of this act if the patient paid the provider for the services, the provider provides proof that the patient has been reimbursed in full and the provider agrees to accept payment for the services under the medical assistance program.

WI **1996 Wis. Laws, Act 191 (AB 547)** establishes that the service provider must collect the allowable copayment, coinsurance, or deductible, unless the service provider determines that the cost of collection exceeds the amount to be collected.

WI **1996 Wis. Laws, Act 442 (AB 1034)** creates the Council on Health Care Fraud and Abuse, attached to the Department of Administration. The council consists of 15 members, including someone with expertise in the medical assistance program, as well as representatives of insurers, employee benefit plan administrators, HMOs, physicians, other health care providers and law enforcement. The council will develop strategies to combat health care fraud and abuse by consumers, providers and insurers, examine problems that relate to electronic claims for payment, survey efforts of other states to reduce fraud and abuse, conduct public hearings and engage in public information programs concerning health care fraud and abuse. The act requires the council to report annually to the governor and the legislature. The report must identify different types of fraud and abuse in health care, analyze related issues such as self-interested referrals, list successful prosecutions of health care fraud that have been conducted in the state courts in Wisconsin, specify activities conducted by the council to combat the problem and recommend specific proposed changes to state statutes or administrative rules the council terminates on December 30, 2000.

WY **1996 Wyo. Sess. Laws, Chap. 111 (HB 92)** enacts welfare reform provisions that limit public and medical assistance programs to five years for any assistance unit within a lifetime. The act allows participants to be sanctioned for failure to adhere to a self-sufficiency plan, but specifies that sanctions must be established in a way that would ensure that children in noncompliant households continue to be eligible for Medicaid and food stamps. Individuals with physical or mental disabilities who otherwise qualify for assistance are not subject to the limitations of the act.

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MINORITY HEALTH

AL	**1996 Ala. Acts, Act 704 (H 327)** makes an appropriation from the Education Trust Fund to the sickle cell education program for the fiscal year ending September 30, 1997.
AL	**1996 Ala. Acts, Act 727 (H250)** creates the Alabama Sickle Cell Oversight and Regulatory Commission and provides for its power, duties and appointments.
DE	**Vol. 70 Del. Laws, Chap. 516 (SB 418)** reauthorizes the Delaware Institute of Medical Education and Research (DIMER) by reconstituting it as an advisory board to the Delaware Health Care Commission. The act gives the board the responsibility for developing a recruitment program for medical education in conjunction with local colleges and universities to encourage medical school applications from minorities and residents of rural counties and underserved areas of Delaware, in addition to other students interested in pursuing a medical education.
FL	**1996 Fla. Laws, Chap. 292 (HB 437)** requires the Department of Health and Rehabilitative Services to establish a sickle-cell program to the extent that resources are available. The act provides for education and screening as well as cooperation with and grants to, not-for-profit centers.
HI	**1996 Hawaii Sess. Laws, H. Res. 152** urges the governor to reaffirm the trust responsibility of all executive departments to improve the health status of Hawaiians by requesting the Departments of Human Services and Health to redirect resources toward primary prevention activities, requesting the Department of Health to reinstitute health data collecting procedures towards a more complete statistical picture of the health status of Hawaii's minorities and requesting the Department of Health to finalize and submit for review an action plan and timetable for implementation of comprehensive health care initiatives for Hawaiians. The governor is requested to submit findings and recommendations to the legislature no later than 20 days before the convening of the 1997 regular session.
HI	**1996 Hawaii Sess. Laws, S. Res. 151 and H. Res. 152** affirm the vital role that the governor's Pacific Health Promotion and Development Center plays in improving Pacific Islander and Hawaiian health and respectfully requests the governor to continue to provide support for the center's activities.
KS	**1996 Kan. Sess. Laws, Chap. 210 (SB 625)** allows a not-for-profit corporation that is also a medical care facility, an indigent health care clinic, a federally qualified health center, or a local health department to enter into a contract or to employ a licensed dentist to provide dental services to people who are indigent and do not have health insurance, people who are eligible for Medicaid, or people who are qualified for Indian Health Services. A dentist who provides services for the dentally indigent is immune from liability. The act also provides that a dentist who is classified as retired by the board is not required to pay an annual license renewal fee or meet continuing education requirements if the dentist elects to provide dental services to the dentally indigent through one of the entities set out in this act. The provisions of the act expire on July 1, 1998.
MA	**1996 Mass. Acts, Chap. 147 (HB 6004)** creates a new public health commission in Cambridge to replace the city's Department of Health and Hospitals in order to better administer, enhance and

expand the public health services provided by the city. The new public health care system, governed by a new Cambridge Public Health Commission, is to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation and long-term care services in order to create a comprehensive and integrated continuum of care with the goals of promoting health and well-being of all in the system's service area. The commission must file with the city manager and city clerk an annual assessment of the city's public health needs by January 15 each year.

The new public health system is to be committed to the provision of excellent and accessible health services to the community, including programs that are responsive to the multicultural and multilingual composition of the service area and to the particular needs of specific populations, including women and children, adolescents, minorities, the elderly and people at high risk for health problems.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** allows among other things, the commissioner of health to make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner is not dependent upon county agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance program and for covered services.

The commissioner must collect, analyze and report information on collaborative resources and nutrition available to and economic contributions by, migrant farm workers. The commissioner is directed to consult with an advisory committee made up of representatives from migrant-serving agencies, county economic assistance program staff and migrant farm workers and family members. (See chapters on "Access and Reform," "Immigration," "Insurance," "Medicaid," "Newborn Screening," and "Special Health Care Needs" for more information.)

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which among other things continues and expands the Primary Care Physician Loan Repayment Program and adds to the eligibility requirements for residents that they must agree to practice in underserved areas. The acts also enhance the programs efforts to encourage minority participation in medical education. (See chapters on "Access and Reform," "Finance," "Insurance," "Providers," and "Women's Health" for more information.)

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NEWBORN SCREENING

CO **1996 Colo. Sess. Laws, Chap. 222 (HB 1030)** eliminates homocystinuria and maple syrup urine disease from among those conditions for which a newborn is screened pursuant to the Newborn Screening and Genetic Counseling and Education Act. On and after July 1, 1996, requires infants born in the state of Colorado who have received newborn screening to have a second specimen taken to screen for certain health conditions, including phenylketonuria (PKU), galactosemia, cystic fibrosis, hypothyroidism and other metabolic disorders.

FL **1996 Fla. Laws, Chap. 306 (HB 1105)** requires infant screening fees for metabolic disorders and other hereditary and congenital disorders to be billed to licensed hospitals rather than to each separate facility. The act statutorily sets the fee at $20 and requires each birth center to pay the fee for all births over 60 births per year. The act requires the Department of Health and Rehabilitative Services to annually certify the costs of the infant screening program to the Legislature.

HI **1996 Hawaii Sess. Laws, Act 259 (HB 3493)** establishes a newborn metabolic screening special fund to pay for laboratory testing, follow-up testing, educational materials, continuing education, quality assurance, equipment and indirect costs. The act requires the Department of Health to charge a fee of $4 to birthing facilities for each newborn screening kit from July 1, 1996, to June 30, 1997, when the provision sunsets. Money is to be deposited into the fund. The act also requires the department to convene a panel to develop a plan for providing newborn metabolic services to the community. The department is directed to adopt rules to increase the number of newborn screening tests until the plan is completed. The director of health must make an annual report to the Legislature.

IA **1996 Iowa Acts, Chap. 1212 (SF 2448)** appropriates funding for various departments, including the Department of Public Health. The act increases funding for the Iowa Health Family Program from $660,000 in the prior year to $952,000. The program provides services to families and children in pilot counties during the prenatal through preschool years and includes infant mortality and morbidity prevention, child protection, resource mothers to assist pregnant and postpartum women, hospital-based childbirth screening to determine high-risk families, linkage to a medical home and coordination of a range of health and social services.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** requires the commissioner of health to develop a statewide birth defects registry system to provide for the collection, analysis and dissemination of birth defects information. The purpose of the registry is to monitor the trends in birth defects, investigate clusters of birth defects to address concerns with scientific data, identify cases of birth defects for study to establish a cause, increase public awareness and evaluate the effectiveness of certain prevention programs.

NH **1996 N.H. Laws, Chap. 75 (HB 1352)** requires each insurer that issues or renews any policy of accident and health insurance providing maternity benefits for hospital expense, medical-surgical expense, or major medical expense to comply with certain requirements, including in cases where a length of hospital stay is shorter than the current minimum nationally accepted guidelines the insurer must pay for at least two postpartum visits. During one such visit, the collection of an adequate sample from the newborn for screening for genetic and metabolic diseases must take place.

OH **1996 Ohio Laws, S. 199** requires health care policies that cover maternity benefits and the state Medicaid program to cover for a mother and her newborn child a minimum of 48 hours of inpatient care for a normal vaginal delivery, a minimum of 96 hours of inpatient care for a Cesarean delivery and a minimum amount of follow-up care. The act specifies that any decision regarding early discharge of a mother or newborn is the responsibility of the attending physician or nurse-midwife after consulting with the mother. The act also requires the Public Health Council to include in its rules prescribing laboratory tests to detect phenylketonuria in newborns any test that it determines is effective to detect the disorder in newborns younger than 48 hours old.

WV **1996 W. Va. Acts, Chap. 81 (SB 562)** requires the physician, midwife, or other person attending the birth of a child with a congenital deformity to report that birth on prescribed forms to the state Bureau of Public Health within 30 days.

WI **1996 Wis. Laws, Act 386 (SB 94)** removes foster care or treatment foster care workers from the list of people who are allowed to refer an infant to a physician for testing of the infant's bodily fluids for controlled substances due to the mother's use of controlled substances while she was pregnant with the infant. The act removes the requirement that the parent or guardian consent to such a test and adds the stipulation that, in order to test the infant, a physician must determine that the health of the infant may be adversely affected by the controlled substances. Finally, the act eliminates the termination of the testing program.

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NUTRITION

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. The initiative sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, $2 million to Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children; and $1 million to the Women, Infants and Children Food Program.

OH **1996 Ohio Laws, S. 246** prohibits the sale of expired drugs, baby food and infant formula and also prohibits selling at a flea market a product bearing an expiration date or recommended sale or use date.

PA **1996 Pa. Laws, Act 129 (HB 664)** adds wildlife donations to the Donated Food Limited Liability Act to be used for charitable food programs. The act requires the Department of Agriculture to enter into a memorandum of understanding with a recognized, not-for-profit organization registered with the Bureau of Charitable Organizations, under which the organization will serve as program coordinator to make available information, including cooperating processors and charitable and religious organizations which will accept donations of wildlife.

UT **1996 Utah Laws, Chap. 268 (HB 236)** requires each local school board to review, at least every three years, reasons each elementary school in its district does not participate in the school breakfast program. Reasons for nonparticipation include a recommendation from the school community council or a similar group of parents and school employees that the school should not participate. No further action is required if there are valid reasons for nonparticipation. After two reviews, a local board may waive any further reviews.

UT **1996 Utah Laws, Chap. 289 (SB 181)** clarifies the exemption from sales and use tax of purchases made under WIC, the federal special supplemental nutrition program for women, infants and children and modifies the Tax Review Commission's periodic review of this exemption.

WI **1996 Wis. Laws, Act 165 (AB 154)** exempts breast-feeding mothers from the law that makes exposure of sexual organs to a child a Class A misdemeanor.

ORAL HEALTH

KS **1996 Kan. Sess. Laws, Chap. 210 (SB 625)** allows a not-for-profit corporation that is also a medical care facility, an indigent health care clinic, a federally qualified health center, or a local health department to enter into a contract or to employ a licensed dentist to provide dental services to people who are indigent and do not have health insurance, people who are eligible for Medicaid, or people who are qualified for Indian Health Services. A dentist who provides services for the dentally indigent is immune from liability. The act also provides that a dentist who is classified as retired by the board is not required to pay an annual license renewal fee or meet continuing education requirements if the dentist elects to provide dental services to the dentally indigent through one of the entities set out in this act. The provisions of the act expire on July 1, 1998.

PA **1996 Pa. Laws, Act 87 (HB 216)** establishes the Office of Physician General within the Department of Health and provides that the physician general will be appointed by the governor, by and with the advice and consent of the Senate. The act also requires the Department of Health to apportion the Commonwealth into dental health districts, administered by a public health dentist within the department, who shall implement dental health policies and programs for the various counties and political subdivisions.

WI **1996 Wis. Laws, Act 164 (AB 666)** requires the Department of Health and Social Services to submit to the federal Department of Health and Human Services an amendment to the state medical assistance plan to receive federal financial participation for removable prosthodontic services (e.g., dentures and bridges), beginning on the earliest date permitted under federal law. The act also requires the department to pay a provider for removable and fixed prosthodontic services performed between October 1, 1995 and the effective date of this act if the patient paid the provider for the services, the provider provides proof that the patient has been reimbursed in full and the provider agrees to accept payment for the services under the medical assistance program.

PHARMACEUTICALS

CA	**1996 Cal. Stats., Chap. 13 (SB 668)** expands the scope of practice of optometrists to use therapeutic pharmaceutical agents and provide for diagnosis and treatment of specified conditions or diseases of the human eye or its appendages.
CA	**1996 Cal. Stats., Chap. 197 (AB 3483)** suspends, until January 1, 1999, the operative date for the establishment of a drug formulary and requires the Bureau of State Audits to prepare a report by January 1, 1998 on the drug program management techniques and the comparability of the program to other private sector third party payers. The act extends Medi-Cal's authority to contract for single-source and multi-source drugs until January 1, 1999 and extends the 10 percent supplemental rebate program to January 1, 1997.
CA	**1996 Cal. Stats., Chap. 455 (AB 1077)** authorizes certified nurse practitioners to furnish a broader range of drugs and devices, including specified controlled substances, pursuant to standardized procedures and protocols, to a broader range of patients and in additional practice settings.
CA	**1996 Cal. Stats., Chap. 527 (SB 1596)** allows health care plans and health insurers to pay for or reimburse the cost of services provided by pharmacists.
DE	**Vol. 70 Del. Laws, H. Res. 85** requests the secretary of the Department of Health and Social Services to recommend the adaptation of model legislation addressing the approval of off-label medical use of drugs for the purposes of health insurance reimbursements.
FL	**1996 Fla. Laws, Chap. 197 (HB 495)** requires third-party payers to reimburse employers of physician assistants (PAs) for covered services. A supervisory physician may grant a PA the authority to prescribe drugs as long as the medication is listed in the formulary under specified circumstances and specified information is contained on the prescription.
FL	**1996 Fla. Laws, Chap. 296 (HB 537)** revises the regulations and licensure procedures for chiropractors. The act revises the definition of chiropractic to authorize the ordering, storing and administering of prescription medical oxygen and certain topical anesthetics in aerosol form under emergency circumstances only. The act also revises the ground rules related to the prescribing, dispensing and administering of medicinal drugs and the keeping of written chiropractic records.
GA	**1996 Ga. Laws, p. 1037 (H 1265)** appropriates funds for Medicaid services. The act requires the Department of Medical Assistance to exclude pharmacy services in the HMO pilot and allow acute care hospitals statewide to contract with Medicaid for services on a non-risk capitated rate. The act requires the department to implement a clinically based, automated prospective drug utilization review program and designates $100,000 for the independent care program for personal assistance and support.
GU	**1996 Guam Laws, P.L. 23-9** allows optometrists independent use of certain therapeutic pharmaceutical agents as topical preparations and use of additional oral and topical agents under a co-management arrangement with an ophthalmologist.

GU **1996 Guam Laws, P.L. 23-123** requires pharmacies to provide written information for each initial prescription filled by a pharmacy, medical clinic or doctor, giving the name of the drug, the ailment being treated, contraindications, interactions and a list of the most common side effects.

HI **1996 Hawaii Sess. Laws, H. Res. 82** requests that the Department of Health form a working group to develop an implementation plan to ensure that HIV education, counseling and testing is offered to women of childbearing age and that AZT treatment is offered to HIV positive women if appropriate. The working group is to report on its progress no later than 20 days before the convening of the 1997 regular session.

HI **1996 Hawaii Sess. Laws, Act 287 (HB 2800)** makes appropriations for health care payments, provided that a study be conducted on the various drug therapies used in the Med-QUEST Program. The study must include detailed clinical analysis of the health care benefits of various drug treatments and economic analysis of the health care savings of various drug treatments and an analysis of the quality and scope of various drug treatments which are currently prescribed, including more expensive treatments. The study also must include an examination of alternatives which will make additional funds available for the purchase of various drug therapies, provided that the study include drug treatments that vary from the current costs of the prescribed generic agents. The Department of Human Services must submit results of the study to the Legislature no later than 20 days before the convening of the 1997 regular session.

HI **1996 Hawaii Sess. Laws, Act 292 (HB 2647)** increases accessibility to certain kinds of health care for the eye while maintaining standards of care by authorizing the Board of Examiners in Optometry to certify qualified optometrists to use and prescribe topical therapeutic pharmaceutical agents determined by a committee of health care professionals.

IN **1996 Ind. Acts, P.L. 114 (SB 414)** provides that when a Medicaid recipient does not make the required copayment, the office of Medicaid policy and planning may not require a Medicaid provider to collect the copayment. The act also authorizes a licensed pharmacist to adjust a patient's drug regimen in a health care facility under certain circumstances.

KS **1996 Kan. Sess. Laws, Chap. 179 (SB 152)** adds to the duties that a registered nurse anesthetist may perform under order of a physician or dentist, including developing a general plan of anesthesia care, selecting the method for administration of anesthesia or analgesia, selecting appropriate medications and anesthetic agents and inducing and maintaining anesthesia or analgesia at the required levels.

KY **1996 Ky. Acts, Chap. 342 (HB 358)** authorizes advanced registered nurse practitioners to prescribe legend drugs under certain conditions, requires continuing education in pharmacology and requires written collaborative agreements with physicians.

LA **1996 La. Acts, Sen. Concur. Res. 52** requests the Louisiana Health Care Authority and the Louisiana Primary Care Association to jointly develop a pilot program to provide prescription drugs for the authority's indigent outpatients.

ME **1996 Maine Laws, Chap. 665 (LD 1759)** appropriates funds for several health and human services programs and requires that pharmacies pay a 25 cent per prescription processing service fee on every Medicaid prescription to be deposited into the Medical Care-Payments to Providers Special Revenue account.

ME **1996 Maine Laws, Chap. 671 (LD 1852)** establishes the Board of Complementary Health Care Providers to regulate the practice of naturopathic doctors and acupuncturists. The act allows naturopathic doctors to prescribe nonprescription medications without limitation and to prescribe those noncontrolled legend drugs that the doctor judges are consistent with the doctor's education and training. The board may further restrict naturopathic doctors' prescriptive authority regarding noncontrolled legend drugs by rule. Before independently prescribing noncontrolled legend drugs, a naturopathic doctor must establish and complete a 12-month collaborative relationship with a licensed allopathic or osteopathic physician to review the naturopathic doctor's prescribing practices. The board shall further define the terms of the collaborative relationship by rule. The act forbids a naturopathic doctor from prescribing, dispensing, or administering any substance or device identified in Schedules I-V or and controlled substances or devices. A naturopathic doctor is not allowed to perform surgical procedures or practice emergency medicine except for the care of minor injuries as a good Samaritan rendering gratuitous services in the case of emergency. The practice or claim to practice medicine and surgery, osteopathy, dentistry, podiatry, optometry, chiropractic, physical therapy, or any other system or method of treatment authorized in this act.

ME **1996 Maine Laws, Chap. 673 (LD 1882)** creates the Maine Health Care Reform Act of 1996, which institutes health plan improvements and provides for the creation of private purchasing alliances. The act creates a licensing and regulatory process to allow the establishment of private purchasing alliances in Part A. Private purchasing alliances are nonprofit corporations licensed by the Bureau of Insurance to provide health insurance to members through multiple unaffiliated participating carriers. When established, an alliance must offer a range of health plans from at least three different carriers within the alliance's service area. One of these health plans must be a catastrophic plan providing coverage for inpatient hospital benefits only.

The act requires health plans to provide prospective and current enrollees and providers specified information about the terms and conditions of the plan to enable those people to make informed decisions regarding their choice of plans. In addition to information about services covered, services not covered, copayments and deductibles, restrictions on particular provider types, how the plan addresses the provision of appropriate and accessible care in a timely fashion and other details, the plans must provide information about procedures an enrollee must follow to obtain drugs and medicines that are subject to a plan list or formulary, if any.

MD **1996 Md. Laws, Chap. 102 (SB 104)** repeals the publication requirement and allows the medical assistance program to pay for a generic drug as soon as it is added to the state formulary.

MA **1996 Mass. Acts, Chap. 203 (HB 6107)** establishes a program of pharmacy assistance for certain people with disabilities and elderly people who are not eligible for medical assistance or other third-party coverage for pharmacy benefits.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** requires the commissioners of health, human services and administration to develop a plan to provide prescription drugs at significantly discounted prices to individuals 65 years or older whose income is below 200 percent of the current federal poverty level. The commissioners are to submit a report to the legislature detailing the plan by October 1, 1996. (See "Access and Reform" for additional information about this act.)

MS **1996 Miss. Laws, Chap. 578 (S 2759)** directs the division of Medicaid to develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings. In no case may the total payment exceed twice the amount of the dispensing fee.

NJ **1996 N.J. Laws, Sen. Res. 20** memorializes the U.S. Congress to enact comprehensive legislation to facilitate the rapid review and approval of innovative new drugs, biological products and medical devices, without compromising patient safety or product effectiveness.

OH **1996 Ohio Laws, H. 595** permits registered pharmacists to sell dialysis drugs and supplies directly to the patients for self-administration, according to a physician's orders. The act exempts them, when selling dialysis drugs and supplies for self administration, from certain prescription record-keeping requirements and requirements that registered pharmacists sell the drugs and control their pharmacies. In the case of an applicant who is a retail seller of peritoneal dialysis solutions in original packages, the applicant must maintain supervision and control over the possession, custody and retail sale of the peritoneal dialysis solutions.

OH **1996 Ohio Laws, S. 107** concerns the use of "off-label drugs" and modifies the prohibition of health plans that cover prescription drugs from limiting or excluding coverage of a federally approved drug on the basis that the drug is not federally approved for treating the specific type of cancer for which it is prescribed, to prohibit exclusion if the drug is recognized in certain medical literature for treating the particular indication for which prescribed.

OH **1996 Ohio Laws, S. 246** prohibits the sale of expired drugs, baby food and infant formula and also prohibits selling at a flea market a product bearing an expiration date or recommended sale or use date. The act authorizes an individual who is certified to conduct diabetes education to possess insulin if the person is professionally licensed, certified, or registered by the state and diabetes education is within the individual's scope of practice; authorizes possession of hypodermic needles for educational purposes; and repeals the prohibition against discarding hypodermics before rendering them unusable.

OK **1996 Okla. Sess. Laws, Chap. 186 (SB 587)** gives limited authority to nurse practitioners to prescribe from a formulary, provided the nurse practitioners have written agreements with supervising physicians.

OK **1996 Okla. Sess. Laws, Chap. 316 (HB 2147)** authorizes the state to join a multi-state purchasing consortium for the purpose of purchasing pharmaceuticals and other medical supplies.

PA **1996 Pa. Laws, Act 35 (SB 1441)** requires any managed care entity under contract to the Department of Public Welfare to contract on an equal basis with any pharmacy qualified to participate in the Medical Assistance Program that is willing to comply with the managed care entity's pharmacy payment rates and terms and to adhere to quality standards established by the managed care entity.

PA **1996 Pa. Laws, Act 134 (HB 544)** requires manufacturers of prescription drugs reimbursed under PACE, PACENET (Programs of Pharmaceutical Assistance to the Elderly) and designated pharmaceutical programs to enter into a rebate agreement with the Department of Aging to obtain reimbursement. The act provides that except for experimental drugs, there shall be no drug formulary, prior or retroactive approval system or any similar restriction imposed on the coverage of outpatient drugs made by manufacturers who have agreements in effect with the Commonwealth to pay rebates for drugs utilized in PACE and PACENET, provided that such out-patient drugs were approved for marketing by the Food and Drug Administration. The act requires each manufacturer with an agreement to report the average manufacturer price for all covered prescription drugs produced by that manufacturer to the department not later than 30 days after the last day of each quarter. The department must retain the services of an independent contractor to survey wholesalers, direct sellers and manufacturers that directly distribute their covered prescription drugs, when necessary, to verify manufacturer prices reported. Information disclosed by manufacturers, wholesalers or direct sellers is confidential and shall not be disclosed by the department in a form which discloses the identity of a specific manufacturer, wholesaler or direct seller or the prices charges for drugs by the manufacturer or wholesaler, except as the department determines to be necessary to carry out the law and to permit the Department of the Auditor General and the Office of State Inspector General to review the information provided.

RI **1996 R.I. Pub. Laws, Chap. 429 (SB 2789)** allows certified registered nurse practitioners to prescribe schedule II-V controlled substances.

TN **1996 Tenn. Pub. Acts, Chap. 651 (S 2091)** adds sections to the Tennessee Pharmacy Practice Act of 1996 defining the practice of pharmacy within the state and the goals of pharmacy practice to protect the health and safety of the residents. The act authorizes pharmacists to conduct and assist patients with tests approved for in-home use, but does not authorize pharmacists to order laboratory tests or prescription drugs except according to a medical order by the attending physician for each patient.

TN **1996 Tenn. Pub. Acts, Chap. 659 (S 2377)** requires the division of health-related boards to provide the board of pharmacy with the names of all nurse practitioners and physician assistants who are authorized to issue prescriptions and legend drugs and the names of their supervising physician. For each nurse practitioner, the board should also receive the list of drugs and the prescriptive services that may be issued by the nurse. It is understood that any prescription made by a nurse practitioner

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is under the control of the supervising physician. Any nurse practitioner or physician assistant who has been given authority to prescribe legend drugs must file a notice with the Primary Care Advisory Board giving his or her name, the supervising physician and a copy of the list describing the categories of legend drugs that may be prescribed. Both the nurse practitioner and physician assistant must maintain the protocol of their services, which will remain readily accessible to anyone upon request.

TN **1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)** directs the legislative oversight committee on TennCare to conduct an independent study of the TennCare pharmacy program that looks at grievance procedures, a monitoring process to ensure prompt reimbursement without disrupting patient care, disclosure measures to ensure patients are informed about the scope of the pharmaceutical benefit, ways to ensure the scientific and clinical integrity of health care decisions affecting TennCare enrollees and safeguards to preserve a competitive marketplace and the continuation of critical medical research and development.

The act authorizes the TennCare Bureau, the TennCare Pharmacy Board and the Department of Finance and Administration to provide necessary assistance to the oversight committee in conducting its study. The oversight committee is authorized to invite TennCare managed care organizations, TennCare providers, pharmacists, pharmaceutical manufacturers and voluntary health associations to participate in the study. The oversight committee must report its findings and recommendations no later than January 10, 1997, to legislative health committee chairs and the special joint committee to study women's health. The TennCare Bureau must file a report at least annually setting forth data and statistics relative to health care provided to women.

UT **1996 Utah Laws, Chap. 247 (SB 79)** creates a new "Pharmacy Practice Act" that defines terms relating to the practice of pharmacy in all areas, defines the regulations concerning pharmaceutical wholesale and distribution practices and defines unprofessional conduct and the penalties that will be incurred by any individual in violation of this act.

A manufacturer, wholesaler, or distributor of prescription drugs may not sell or give any prescription drugs to anyone unless the stock container bears a label containing the name and business of the manufacturer as well as the address. The act defines the terms and limitations on distribution of pharmaceutical manufacturers or wholesalers.

Third-party payers for pharmaceutical services within the state may not require any pharmacy patient to obtain a drug from out-of-state as a condition for obtaining third-party payment. However, this act does not limit the right of the payer to determine the amount that will be reimbursed for the cost of prescription drugs based upon the costs of identical prescription drugs available through an out-of-state pharmacy. The act defines the distinction between a prescription drug and a non-prescription drug. This act allows pharmacists or pharmacy interns who are dispensing a prescription order for a specific drug brand to substitute another drug product equivalent if the purchaser specifically asks for the alternative drug or it is labeled as the therapeutic equivalent by the Center for Drug Evaluation and Research of the Food and Drug Administration (FDA). The act dictates that the substitution of any drug by a licensed pharmacist or pharmacy intern does not constitute the practice of medicine. Finally, the act defines the terms by which refills can be obtained and describes the necessary information that should be included on a prescription.

VT **1996 Vt. Acts, Act 74 (H 534)** restricts further enrollment in the Vermont Health Access "Interim" Program after April 15, 1996, unless rules have been adopted by that date under the Administrative Procedure Act to implement that program and to implement the Vermont Health Access "Pharmacy" Program.

WA **1996 Wash. Laws, Chap. 312 (SB 6392)** requires health carriers to disclose whether a plan provider is restricted to prescribing drugs from a plan list, what drugs are on the list and the extent to which enrollees will be reimbursed for drugs that are not on the list.

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WV **1996 W. Va. Acts, Chap. 205 (SB 133)** amends and updates licensure requirements for physician assistants. The act allows physician assistants, under the supervision of a certified physician, to prescribe categories of drugs that are delineated in their job descriptions. To be eligible for prescriptive privileges, a physician assistant must have performed at least two years of patient care services and completed an accredited course in clinical pharmacology. To maintain prescriptive privilege status, a physician assistant must complete a minimum of 10 hours of continuing education in rational drug therapy in each certification period.

PRENATAL CARE AND INFANT MORTALITY REDUCTION

(SEE INSURANCE SECTION FOR MATERNITY HOSPITAL STAY LEGISLATION)

AZ **1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)** requires the director of the Arizona Health Care Cost Containment System to apply to the federal Health Care Financing Administration for authorization to reimburse services performed by eligible licensed midwives.

AZ **1996 Ariz. Sess. Laws, Chap. 240 (HB 2358)** excludes those who assist in the preparation for labor and delivery of a baby or who assist in the actual delivery from licensing requirements established for midwives and any criminal or civil penalties for infraction affecting midwife licensure. The exclusion does not apply to those who advertise as midwives or midwifery service providers, accept compensation for services, or indicate they are midwives.

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, including $2 million to Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children. (See "Insurance" for length of study.)

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the following programs funded by Cigarette and Tobacco Products Surtax Fund money: Comprehensive Perinatal Outreach, selected primary care clinics, Access for Infants and Mothers, County Medical Services Program and emergency treatment of out-of-county indigent patients. The act revises reporting and maintenance of effort requirements under the California Health Care for the Indigent Program.

CT **1996 Conn. Acts, P.A. 96-160 (SB 28)** eliminates the requirement that the Department of Public Health (DPH) reserve two percent of the Maternal and Child Health Protection Program's funds for program evaluation. The act requires the DPH to evaluate the program using outcome measures developed in consultation with the Office of Policy and Management. The Maternal and Child Health Protection Program provides outpatient maternal health services and labor and delivery services to needy women and health services to children under age 6. DPH must contract with local health service providers to serve families with an adjusted gross income at or under 185 percent of federal poverty guidelines who do not have private insurance that covers these services.

DE **Vol. 70 Del. Laws, Chap. 520 (HB 626)** requires all licensed health care providers who render primary prenatal care to advise pregnant women of the value of HIV testing and to request that each pregnant woman give informed consent to be tested. Practitioners should also counsel pregnant women who are found to be HIV-positive about the dangers to her fetus and the advisability of receiving treatment in accordance with the Centers for Disease Control and Prevention recommendations for HIV-positive pregnant women. Any pregnant woman has the right to refuse consent to HIV testing and any recommended treatment. Documentation of such refusal must be maintained in the patient's medical record.

DE **Vol. 70 Del. Laws, Sen. Concur. Res. 73** encourages health insurance policies to cover prescription strength prenatal vitamins under their prescription plans.

FL **1996 Fla. Laws, Chap. 179 (SB 474)** requires physicians and midwives to offer HIV testing to all pregnant patients as the prevailing standard of care. Those who attend patients who have been offered but refused testing will be immune from liability arising from the subsequent transmission of HIV infection from the mother to the child.

HI **1996 Hawaii Sess. Laws, H. Res. 82** requests that the Department of Health form a working group to develop an implementation plan to ensure that HIV education, counseling and testing is offered to women of childbearing age and that AZT treatment is offered to HIV positive women if appropriate. The working group is to report on its progress no later than 20 days before the convening of the 1997 regular session.

ID **1996 Idaho Sess. Laws, Chap. 227 (H 553)** amends existing law to provide enhanced penalties for battery if the victim is pregnant and the defendant knows the victim is pregnant.

IL **1996 Ill. Laws, P.A. 89-507 (HB 2632)** directs that the Departments of Alcoholism and Substance Abuse; Mental Health and Developmental Disabilities; and Rehabilitative Services are to become the Department of Human Services (DHS) on July 1, 1997. The new agency will also succeed to all powers of the Department of Children and Family Services to coordinate day-care resources and to provide direct child welfare services; supportive services and living maintenance to pregnant, unmarried minors; and shelter and independent living services for homeless youth. DHS will also have responsibility for these health issues: infant mortality reduction; diabetes prevention; addicted pregnant women; and hemophilia treatment. It will succeed to all powers of the Department of Public Health as to the federal Women, Infants and Children (WIC) Program and to some other powers of the Departments of Public Aid, Public Health and Children and Family Services. (Note: HB 22-- P.A. 89-506 creates a Task Force on Human Services Consolidation appointed by the governor and legislative leaders to gather facts and make recommendations on further human services consolidations and report in early 1997, 1998 and 1999.)

IA **1996 Iowa Acts, Chap. 1212 (SF 2448)** appropriates funding for various departments, including the Department of Public Health. The act increases funding for the Iowa Health Family Program from $660,000 in the prior year to $952,000. The program provides services to families and children in pilot counties during the prenatal through preschool years and includes infant mortality and morbidity prevention, child protection, resource mothers to assist pregnant and postpartum women, hospital-based childbirth screening to determine high-risk families, linkage to a medical home and coordination of a range of health and social services.

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LA **1996 La. Acts, Sen. Concur. Res. 22** requests the Commission on Perinatal Care and Prevention of Infant Mortality to invite the secretary of the Department of Social Services or his designee and the superintendent of the state Department of Education or his designee, to attend the meetings of the commission.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds. The department must obtain from those HMOs and clinic plans with which the department contracts patient-based utilization data, including immunizations, early and periodic screenings, diagnoses and treatments, substance abuse services and maternal and infant support services referrals. The format and frequency of reporting shall be specified by the department. The reports shall be distributed to the members of the Senate and House Appropriations Subcommittees on Community Health, the Senate and House fiscal agencies and the director of each local health department.

The act specifies that the mother of an unborn child must be eligible for medical services benefits for herself and her child if all other eligibility factors are met. To be eligible for these benefits, the applicant must provide medical evidence of her pregnancy, or if she is unable to provide the documentation, payment for the examination may be at state expense. The Department of Community Health must undertake such measures as may be necessary to ensure that necessary prenatal care is provided to medical services eligible recipients. The department may only contract with health plans which cover a minimum length of postpartum stay at a hospital that is consistent with the minimum postpartum hospital stay standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

MN **1996 Minn. Laws, Chap. 440 (SF 2410)** specifies that provider organizations and individual health care providers are to use the first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration (HCFA) as their unique provider number. The act establishes procedures for disclosing certain non-public data to related group purchasers. The act authorizes the commissioner of Human Services to publish, or release to the public by other means, the named identity of a group purchaser as part of an analysis of information collected from the birth registration. Analysis means the identification of trends in prenatal care and birth outcomes associated with group purchasers. The commissioner may not reveal the named identity of the group purchaser until the group purchaser has had 21 days after receipt of the analysis to review the analysis and comment on it. In releasing data, the commissioner must include comments received from the group purchaser related to the scientific soundness and statistical validity of the methods used in the analysis. The provision does not authorize the commissioner to make public any individual identifying data except as permitted by law.

NY **1996 N.Y. Laws, Chap. 649 (A 11329)** extends the statutory authority for the state's Medicaid Managed Care Program for four additional years, to July 1, 2000, in order to continue existing managed care programs. The act transfers primary responsibility for the program from the Department of Social Services to the Department of Health (DOH). The act specifies Medicaid recipients who are and are not mandated to participate in managed care, making allowances for people with special health care needs and situations such as geographic proximity to managed care providers. Mandatory enrollment in managed care may be deferred for pregnant women who have an established relationship with a comprehensive prenatal care provider that is not associated with a managed care provider in the program. The act provides a limited extension of benefits for certain pregnant women who lose Medicaid eligibility due to income in excess of the established medically needy income level.

TN **1996 Tenn. Pub. Acts, Chap. 964 (H 2364)** provides that any health plan that provides coverage for pregnancy and/or maternity benefits may not be canceled or terminated due to the pregnancy of an enrollee. The act provides that if and only if, a person or the person's spouse is pregnant at the time the health insurance coverage is initially purchased, then pregnancy and/or maternity benefits for the current pregnancy may be denied as a preexisting condition. The act applies to all people who should have been entitled to coverage for such benefits on or after January 1, 1996.

The act also authorizes the Department of Commerce and Insurance and the Department of Finance and Administration to promulgate permanent rules establishing minimum standards of coverage for maternity benefits offered by insurers. The rules are to establish standards sufficient to protect and promote the health, safety and well-being of both the postpartum mother and her newborn and recognize the relationship between the mother and physician.

TN **1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)** requires the TennCare Bureau to file a report at least annually setting forth data and statistics relative to health care provided to women. The act directs the TennCare Bureau and the Tennessee Department of Health to develop data measures to assess the effectiveness of presumptive eligibility, the distribution of providers for each managed care organization for TennCare enrollees within each health region and the incidences of early prenatal care for TennCare recipients. The managed care organizations are required to report regularly to the TennCare Bureau using the data measures developed.

TN **1996 Tenn. Pub. Acts, H. Jt. Res. 431** continues the special joint committee to study women's health issues for two years to further study and make recommendations on numerous other women's health issues, including prenatal care.

UT **1996 Utah Laws, Chap. 206 (SB 194)** provides that if an insured person has coverage for maternity benefits, the policy must cover any prenatal or maternity expenses of a birth mother or child, if the child is placed for adoption with the insured within 30 days of the child's birth. In the case of a managed care plan or HMO, if the birth mother is identified and arrangements for adoption begin before the child's birth, the insured must notify the plan. The plan may require compliance by the birth mother with the managed care terms and conditions of the contract in order for the insured to be entitled to the full prenatal and maternity benefit. If the birth mother does not comply, the amount of reimbursement to the insured may be limited to the applicable out-of-plan benefit.

If the insured changes insurance policies after medical services have been rendered to a birth mother or child, each insurer will only be required to reimburse the insured for the expenses that occurred during the time that the insured was covered for maternity benefits under that insurer's policy. If the insured is covered by two or more policies at the same time, expenses must be divided equally between the insurers, unless the terms of the policies, when considered together, provide for a different division.

If the adoption of the child placed with the insured is not finalized within one year of the child's birth, the insurer may seek reimbursement from the insured for any payment made under this act. If a policy offers optional maternity benefits, the insurer also must offer, on the same terms and conditions, optional coverage for prenatal or maternity expenses of a birth mother and child where the child is adopted by the insured and the adoption is finalized within nine months of the child's birth. To the extent permissible by law, an adoptive parent's insurer that provides a benefit under this act will be considered a secondary plan for the purpose of coordinating.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** amends the HMO act, adding sections pertaining to quality assurance, reimbursement for ambulance services, rural HMOs and other reforms. The definition of primary care physician is amended to allow a certified nurse-midwife to be chosen in lieu of a subscriber's primary care physician during the subscriber's pregnancy and for a period extending through the end of the month in which the 60-day period following termination of pregnancy.

PREVENTION AND PRIMARY CARE

AZ **1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)** amends the definition of primary care disciplines to include family medicine, general internal medicine, general pediatrics and obstetrics and gynecology. This definition is amended for purposes of the mandate on the University of Arizona School of Medicine to reserve at least 60 percent of its available residency positions for medical school graduates entering programs defined as primary care disciplines of which at least 12 percent must be reserved for medical school graduates entering the family medicine program.

The act also amends the rural health professions program and requires the three universities under the jurisdiction of the Arizona Board of Regents to select 10 nurse practitioner students, 15 medical students and four pharmacy students each year to participate in the rural health professions program. The university must attempt to ensure that each individual participating student be able to fulfill the program requirements in a single rural practice setting. Pharmacy and medical students in the program will be placed in rural settings for a duration of at least one month during the summer months between academic years as part of the required curriculum during a clinical clerkship and in the final year of training. Nurse practitioner students in the program will be placed in rural settings in the state during the summer months between their first and second academic year.

AZ **1996 Ariz. Sess. Laws, Chap. 247 (HB 2277)** appropriates a total of $5.4 million from the general fund in both fiscal years 1996-97 and 1997-98 to the Department of Economic Security for continued implementation of the healthy families pilot program ($3 million); and the Department of Health Services (DHS) for continued implementation of the healthy start pilot program ($400,000).

The act requires DHS to conduct a study to assess the feasibility of comprehensive program coordination for the healthy start pilot program, including an assessment of the program's goals and the needs of the target populations. DHS is required to report its findings to the Joint Committee on Community Program Evaluation by October 1, 1996. The act requires the joint committee to recommend criteria, by October 1, 1996, for DHS to use in determining which contractors to hire for the healthy start pilot programs, developing a screening method to determine which women are most in need of services and selecting what services are needed.

AZ **1996 Ariz. Sess. Laws, Chap. 288 (SB 1283)** changes the criterion for awarding contracts to managed care organizations under Medicaid from the "lowest qualified bids" to "proposals determined to be the most advantageous to the state."

The act continues the ability to use Arizona Health Care Cost Containment System (AHCCCS) fee-for-service rates or negotiate rates for health plans and program contractors in rural counties.

The act broadens the definition of a qualifying community health center and requires AHCCCS to develop rules and provide for a copayment by members for transportation (for example, ambulance service) in a non-emergency circumstance.

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AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor.

Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, to be allocated as follows: $5 million to the Healthy Families Program, which provides services to prevent child abuse and neglect and to promote child wellness and proper development; $4 million to the Arizona Health Education System to provide scholarships to medical students who agree to practice in areas of the state that are currently underserved by health care professionals; $3 million to programs to prevent teenage pregnancy; $2 million for disease control research; $2 million to Healthy Start, a program that aims to reduce the incidence of low-birthweight babies and childhood diseases and to educate families on the importance of good nutrition and preventative health care for their children; and $1 million to the Women, Infants and Children Food Program.

Previously, lottery revenues were earmarked for deposit in economic development, local transportation assistance and two state heritage funds. Under Proposition 203, the $17 million will be distributed only after the economic development, local transportation assistance and heritage funds receive their full appropriations.

CA **1996 Cal. Stats., Chap. 148 (AB 3097)** allows private, nonprofit hospitals in certain counties to enter into joint powers of agreement with public agencies to provide public health care services.

CA **1996 Cal. Stats., Chap. 197 (AB 3483)** establishes a state-only family planning program under Medi-Cal, for a period of three years to provide family planning services to all those with family incomes at or below 100 percent of the federal poverty level, who have no other health care coverage, except as described and are not otherwise eligible for Medi-Cal services without a share of cost. (See "Medicaid" for more information.)

CA **1996 Cal. Stats., Chap. 199 (AB 3487)** extends the following programs funded by Cigarette and Tobacco Products Surtax Fund money: Comprehensive Perinatal Outreach, selected primary care clinics, Access for Infants and Mothers, County Medical Services Program and emergency treatment of out-of-county indigent patients. The act revises reporting and maintenance of effort requirements under the California Health Care for the Indigent Program.

CT **1996 Conn. Acts, P.A. 96-229 (HB 5794)** requires local and regional boards of education to provide annual posteral screenings for students in grades five through nine. Previously, such screenings were required only in the fifth and eighth grades.

DE **Vol. 70 Del. Laws, Sen. Jt. Res. 19** resolves that the Department of Public Instruction and the Department of Health and Social Services submit a plan analyzing existing capacity to educate the state's citizens about cancer and related chronic diseases and their risk factors. The plan should include ways to improve educational efforts; and an estimate of the costs to provide adequate public education, including start-up costs and annual operation and maintenance costs. In addition, the plan should examine existing coordination efforts between the two departments and between the departments and the voluntary and private health providers with an interest in cancer education and explain how the departments intend to coordinate future efforts, including school-based health centers, in developing expanded comprehensive health education. The proposal should also evaluate how existing school health curricula are being implemented at the local and district levels and make recommendations on a public awareness campaign about the risks of tobacco use targeted at youth and how to incorporate skill-building activities for healthier alternative behaviors in comprehensive school health education programs at all levels. The plan should also address how to educate the general population on the prevention of chronic diseases in general and cancer specifically. The plan must be submitted to the General Assembly on or before January 1, 1997.

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DC **1996 D.C. Stats., Act 11-486 (Bill No. 11-962)** amends, on an emergency basis due to congressional review, the Free Clinic Assistance Program Act of 1986 to extend the life of the program until September 23, 2001.

FL **1996 Fla. Laws, Sen. Res. 1824** recognizes April as "Early Intervention Awareness Month" and urges all residents to support the state's early intervention programs and services that promote healthy environments and optimal development for children.

HI **1996 Hawaii Sess. Laws, H. Res. 152** urges the governor to reaffirm the trust responsibility of all executive departments to improve the health status of Hawaiians by requesting the Departments of Human Services and Health to redirect resources toward primary prevention activities, requesting the Department of Health to reinstitute health data collecting procedures towards a more complete statistical picture of the health status of Hawaii's minorities and requesting the Department of Health to finalize and submit for review an action plan and timetable for implementation of comprehensive health care initiatives for Hawaiians. The governor is requested to submit findings and recommendations to the legislature no later than 20 days before the convening of the 1997 regular session.

HI **1996 Hawaii Sess. Laws, S. Res. 151 and H. Res. 152** affirm the vital role that the governor's Pacific Health Promotion and Development Center plays in improving Pacific Islander and Hawaiian health and respectfully requests the governor to continue to provide support for the center's activities.

IA **1996 Iowa Acts, Chap. 1212 (SF 2448)** appropriates funding for various departments, including the Department of Public Health. The act increases funding for the Iowa Healthy Family Program from $660,000 in the prior year to $952,000. The program provides services to families and children in pilot counties during the prenatal through preschool years and includes infant mortality and morbidity prevention, child protection, resource mothers to assist pregnant and postpartum women, hospital-based childbirth screening to determine high-risk families, linkage to a medical home and coordination of a range of health and social services.

KY **1996 Ky. Acts, Chap. 186 (SCR 96)** reauthorizes the Commission on Poverty and directs the Legislative Research Commission to appoint a 21-member commission to evaluate the ability of existing poverty and development programs to mitigate the causes of poverty in various areas of the state and to report its findings to the Legislative Research Commission by August 31, 1997.

ME **1996 Maine Laws, Chap. 598 (LD 1722)** enables establishment of a nonprofit corporation known as the Maine Center for Public Health Practice to plan, promote and coordinate health services research, training and policy efforts utilizing a consortium of public and private organizations within the state, including the public university system. The center's research and demonstration efforts may include the cause, effects, extent and nature of illness and disability among all or a particular group of the people of the state, the impact of personal illness and disability on the state economy, the quality and availability of health resources, access to and use of health care services by all or a particular group of the people, including the use of ambulatory health care services and public health policies and programs.

MD **1996 Md. Laws, Chap. 335 (HB 1330)** creates a state debt not to exceed $100,000 with a matching fund requirement as a grant to the board of directors of Health Care for the Homeless Inc. for the repair, renovation and equipping of a building in Baltimore City that is used as a support center for the homeless where physical and mental health care, crisis intervention and other services are provided.

MD **1996 Md. Laws, Chap. 352 (SB 750)** authorizes the state to submit a section 1115 Medicaid waiver proposal to the federal Health Care Financing Administration (HCFA) and specifies that its provisions must include authorizing the Department of Health and Mental Hygiene to require program recipients to enroll in managed care organizations, to prohibit managed care organizations from enrolling program recipients and to require managed care organizations to include providers who have historically served program recipients. The act defines certain terms and includes provisions relating to eligibility and managed care organizations under the Maryland Medical Assistance Program.

The Health Resources Planning Commission, in consultation with the department and the Health Services Cost Review Commission, must study the existing impact on existing community health centers and other primary care providers of the laws, regulations, the grant of federal waiver and other governmental actions that authorize or require the enrollment of Maryland Medical Assistance Program recipients into managed care plans or organizations. The study must include an assessment of the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The study also must include an examination of the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. The commission must submit a report on the results of its investigation and study, together with any resulting policy recommendations, to the governor, the secretary of health and mental hygiene and the General Assembly on or before November 1, 1996.

The act also specifies that managed care organizations are responsible for providing primary mental health services under the program.

MD **1996 Md. Laws, Chap. 549 (HB 1390)** requires the Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review Commission, to assess the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The act also directs the commission to examine the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. A report on the results of the commission's investigation, together with any resulting policy recommendations, is due on or before November 1, 1996.

MA **1996 Mass. Acts, Chap. 147 (HB 6004)** creates a new public health commission in Cambridge to replace the city's Department of Health and Hospitals in order to better administer, enhance and expand the public health services provided by the city. The new public health care system, governed by a new Cambridge Public Health Commission, is to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation and long-term care services in order to create a comprehensive and integrated continuum of care with the goals of promoting health and well-being of all in the system's service area. The commission must file with the city manager and city clerk an annual assessment of the city's public health needs by January 15 each year.

The new public health system is to be committed to the provision of excellent and accessible health services to the community, including programs that are responsive to the multicultural and multilingual composition of the service area and to the particular needs of specific populations, including women and children, adolescents, minorities, the elderly and people at high risk for health problems.

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** delays from July 1, 1995, to October 31, 1997, the date that all managed care organizations must file biennial action plans describing the actions the managed care organization has taken and those it intends to take to contribute to achieving public health goals for each service area in which an enrollee of the managed care organization resides. (See "Medicaid" for more information.)

MS **1996 Miss. Laws, Chap. 440 (SB 2573)** establishes a student vision screening program within the state Department of Education to make eye screening services available to public school students. The act also provides for the appointment of an advisory committee to review vision screening services offered under contract with the state Department of Education.

NE **1996 Neb. Laws, L.B. 1155** changes the definition of health clinic to exempt facilities that provide only routine health screening, health education and immunizations from licensing requirements. The act also provides that health care practitioners who relocate into a health professional shortage area can qualify for the state loan repayment program.

NH **1996 N.H. Laws, Chap. 81 (HB 1509)** makes certain retired physicians immune from civil liability for volunteer health education services when providing education in good faith, without compensation in public forums or in responses to individual inquiries from members of the public. Education does not include advice given to individual members of the public in the nature of diagnosis or treatment.

NH **1996 N.H. Laws, Chap. 146 (HB 1306)** exempts community health clinics under the state licensure law.

NH **1996 N.H. Laws, Chap. 193 (SB 590)** establishes a committee to study the feasibility of requiring insurers to cover early intervention services.

NH **1996 N.H. Laws, Chap. 290 (SB 656)** expands drug-free school zones to include Head Start facilities.

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which continues only until December 31, 1996, existing provisions of the state's hospital reimbursement rate-setting law. The acts continue beyond 1996 until December 31, 1999, the same rate-setting methodology only for Medicaid and certain other payers. The acts deregulate the payment system for most other payers, on and after January 1, 1997, by allowing them to negotiate with hospitals to establish their own payment rates.

The acts establish a number of new provisions for the financing of "public goods programs" on and after January 1, 1997. Insurers and other payers must pay allowances on payments for services rendered, as well as per-person payments for each individual or family member covered by the insurer ("covered lives assessments"), which go into a pool to fund the public goods programs. Funds from these payments, as well as certain Medicaid funds and other payments, are used to finance the costs of graduate medical education, various insurance programs for the uninsured, primary care development, emergency medical services training and health facility restructuring and provider networking programs designed to assist providers in adapting to the changing health care environment.

For example, the acts authorize the commissioner of health to distribute funds in the health care initiatives pool for the Child Health Plus Program ($120 million in 1997, $164 million in 1998 and $181 million in 1999), the Small Business Health Insurance Partnership Program, the Voucher Insurance Program, the Individual Subsidy Program, the Catastrophic Health Care Expense Program, the Primary Health Care Services Pool and the Primary Care Education and Training Program (including the loans, scholarships and medical education grants for minority participation).

The acts continue and expand the Primary Care Physician Loan Repayment Program and add to the eligibility requirements for residents that they must agree to practice in underserved areas. The acts also enhance the programs efforts to encourage minority participation in medical education.

The acts create a new State Task Force on Health Care Quality Improvement and Information Systems within the Department of Health and authorize the commissioner of health to award grants to support collaborative community-based efforts to improve health status and quality of care.

The acts make permanent the Child Health Plus Program, through which primary and preventive health services are provided to eligible children, expand the program by increasing the age limit for eligibility, add coverage for hospital and related inpatient services and make several other changes. Participating insurers must impose a copayment of $2 per visit for physician services, in addition to the other copayments and coinsurances for which insurers are permitted to require payment.

The acts allow Rural Health Network Development Grants to be used to support activities and organizational costs, including the recruitment of qualified health care professionals, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community-based primary care systems and the integration and expansion of prehospital emergency medical services. The acts create a new "Rural Health Care Access Development Program," through which grants and financial assistance can be provided to general hospitals classified as rural hospitals under federal or state regulations, in recognition of the unique costs incurred by these facilities in providing hospital services in remote or sparsely populated areas. The acts require each hospital's performance in meeting the health care needs of the community, providing charity care services and improving access to health care services by the underserved. (See "Insurance" for more information.)

PA **1996 Pa. Laws, Act 87 (HB 216)** establishes the Office of Physician General within the Department of Health and provides that the physician general will be appointed by the governor, by and with the advice and consent of the Senate. The physician general who must be a practicing physician, is to advise the governor and the secretary of health on health policy; participate in the decision-making process of the department on policies relating to all medical and public health-related issues and in the decision-making process of other executive branch agencies as directed by the governor, review professional standards and practices in medicine and public health; consult with recognized experts on medical and public health matters; coordinate educational, informational and other programs for the promotion of wellness, public health and related medical issues and serve as the primary advocate for such programs; and consult with experts in the state and other states regarding medical research, innovation and development.

The act requires the department to establish a 12-month review program to determine the feasibility and effectiveness of entering into contracts with local health care providers for the operation of state health centers or the provision of equivalent services. The program must utilize the equivalent services provided by three existing state health centers on the effective date of the act, one in an urban area, one in a suburban area and one in a rural area. Other than these three health centers, the act prohibits the department from entering into contracts with any additional private providers that would result in the elimination of any state health center, nor reduce the scope of services currently provided, nor reduce the number of centers. On or before December 31, 1997, the department must submit a report to the General Assembly, which shall include a review and analysis of the three health care centers or of the provision of equivalent services in the review program, including patient utilization and services provided; an analysis of the performance of each local health care provider, including patient satisfaction with the provision of services; a review of other delivery systems for health services in the community, both public and private; a comparison of the cost and effectiveness of the operation of each of the three health care centers by the commonwealth with the cost of the provision of equivalent services by local health care providers; recommendations regarding continuation of the provision of the services previously provided by the three health care centers included in the study program be local health care providers; and recommendations regarding the public and private operation of all remaining health care centers, or the provision of equivalent services, in the Commonwealth.

The act requires the Department of Health to apportion the Commonwealth into dental health districts, administered by a public health dentist within the department, who shall implement dental health policies and programs for the various counties and political subdivisions.

PA **1996 Pa. Laws, Act 141 (HB 2511)** enacts the Volunteer Health Services Act to increase the availability of primary health care services by establishing a procedure through which physicians and other health care practitioners who are retired from active practice may provide professional services as a volunteer in approved clinics serving financially qualified persons and in approved clinics located in medically underserved areas or health professionals shortage areas.

RI **1996 R.I. Pub. Laws, Chap. 100 (HB 8783)** increases RIte Care transition payments to community health centers from $10 to $15 per member per month and designates that payment be made through Rhode Island Health Center Association Inc.

The act addresses uncompensated care and the reimbursement hospitals are eligible to receive for treating patients without coverage. The act states that preservation of the ability of the private acute care hospital system of the state to continue to support an increasing uncompensated care burden is of critical importance to the public health and welfare of the citizens of Rhode Island and that implementation of the section of the Social Security Act that permits the federal government to share in the provision of payments to hospitals that provide a significant amount of uncompensated care is an effective way for the state to assist hospitals in continuing to provide uncompensated care.

RI **1996 R.I. Pub. Laws, Chap. 282 (SB 2844)** adds public park or playground to the areas where anyone caught distributing or manufacturing a controlled substance listed in schedules I or II may be punished by a term of imprisonment or fine, or both, up to twice that authorized by the act, but not exceeding life imprisonment.

TN **1996 Tenn. Pub. Acts, Chap. 954 (H 1684)** allows the state Department of Education to establish pilot programs of community-based early childhood education and pre-kindergarten programs to address the health, educational and social service needs of children ages three and four who live below the poverty line and who are not otherwise eligible for similar programs or who do not have access to such programs and/or who are at risk of educational disadvantage and failure due to circumstances of abuse, neglect, disability, or who are at risk of state custody due to a family dysfunction. A reasonable, sliding fee scale based upon the family's income may be established for a student enrolled in any such program.

All early childhood education and pre-kindergarten programs established under this act must be developed through a system of competitive grants and technical assistance using a collaborative effort of the built upon resources and services within the community. Programs should strive to assist families by providing full-day, year-round services. Programs should include a daily component of developmentally appropriate educational activities and, where possible, child care for the children of parents who need extended day services. The act requires the Department of Education to submit a report of findings and recommendations to the governor, state board of education and General Assembly at least once each year.

TN **1996 Tenn. Pub. Acts, Chap. 1079 (S 3176)** creates the Tennessee Department of Children's Services, with a primary focus on providing services to children who are delinquent, dependent and neglected and those at risk of entering state custody. The act also emphasizes family preservation and requires the department to strive to ensure that health care needs, both preventative and practical, are met; and to pursue to provide appropriate and effective behavioral and mental health treatment.

TN **1996 Tenn. Pub. Acts, H. Jt. Res. 431** continues the special joint committee to study women's health issues for two years to further study and make recommendations on numerous other women's health issues. The resolution also notes that the special joint committee has voted to support the proposed statewide Center of Excellence of Women's Health to be based at the University of Tennessee Memphis-Medical. This proposed Center of Excellence would serve as a national model for women's health in research, prevention and service by providing statewide education efforts in rural and underserved areas and developing health professional training and curriculum in women's health. The University of Tennessee network of providers and agencies across the state would be an integral part of this effort.

UT **1996 Utah Laws, Chap. 4 (HB 10)** requires local school boards to implement rules prescribed by the Department of Health for giving abnormal spinal curvature examinations to students. The rules must include exemptions for students whose parents or guardians feel such an examination violates personal beliefs.

UT **1996 Utah Laws, Chap. 229 (HB 135)** encourages collaboration between school districts, local health departments and private medical providers to determine needs and risks to students' health and develop and implement plans to minimize risks and meet needs. School districts are encouraged to provide one registered nurse for every 5,000 students, or, in districts with fewer than 5,000 students, at a level of service recommended by the Department of Health. The act provides for a School Nursing Services Incentive Program to encourage collaborative planning between school districts and local health departments. Incentive money is available by application and are distributed by formula.

PROVIDERS

AL **1996 Ala. Acts, Act 671 (H 625)** creates the Women's Access to Health Care Act, which provides for the inclusion of obstetricians and gynecologists as primary care physicians and prevents a health benefit plan from requiring a referral from a primary care physician as a condition for the coverage of an obstetrician's or gynecologist's services.

AK **1996 Alaska Sess. Laws, Chap. 5 (SB 123)** makes various changes to the student loan program (including education for health professionals), including the maximum loan amount, loan fees, eligible institutions, obligations of borrowers and repayment requirements. The act also requires the commission to establish funding priorities for the professional student exchange program and allows imposition of fees for institutional review. (See also "Insurance" for regulations that relate to providers.)

AK **1996 Alaska Sess. Laws, Chap. 91 (HB 480)** changes the name of the certificate of authority held by a physician assistant from a registration to a license.

AZ **1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)** requires the director of the Arizona Health Care Cost Containment System (AHCCCS) to apply to the federal Health Care Financing Administration for authorization to reimburse services performed by eligible licensed midwives.

AZ **1996 Ariz. Sess. Laws, Chap. 154 (SB 1016)** extends the board of medical student loans until July 1, 2001 and adds to its duties the responsibility to collect and maintain data on the retention of doctors who practice in rural and other medically underserved areas.

AZ **1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)** amends the definition of primary care disciplines to include family medicine, general internal medicine, general pediatrics and obstetrics and gynecology. This definition is amended for purposes of the mandate on the University of Arizona School of Medicine to reserve at least 60 percent of its available residency positions for medical school graduates entering programs defined as primary care disciplines of which at least 12 percent must be reserved for medical school graduates entering the family medicine program.

The act also amends the rural health professions program and requires the three universities under the jurisdiction of the Arizona Board of Regents to select 10 nurse practitioner students, 15 medical students and four pharmacy students each year to participate in the rural health professions program. The university must attempt to ensure that each individual participating student be able to fulfill the program requirements in a single rural practice setting. Pharmacy and medical students in the program will be placed in rural settings for a duration of at least one month during the summer months between academic years as part of the required curriculum during a clinical clerkship and in the final year of training. Nurse practitioner students in the program will be placed in rural settings in the state during the summer months between their first and second academic year.

AZ **1996 Ariz. Sess. Laws, Chap. 240 (HB 2358)** excludes those who assist in the preparation for labor and delivery of a baby or who assist in the actual delivery from licensing requirements established for midwives and any criminal or civil penalties for infraction affecting midwife licensure. The exclusion does not apply to those who advertise as midwives or midwifery service providers, accept compensation for services, or indicate they are midwives.

AZ **Prop. 203 (ballot initiative), 1996 General Election** makes more low-income people eligible to receive health care under the Arizona Health Care Cost Containment System (AHCCCS), the state's health care system for the poor. Proposition 203 sets aside $17 million each year from lottery revenues to fund six health and nutrition programs, including $4 million to the Arizona Health Education System to provide scholarships to medical students who agree to practice in areas of the state that are currently underserved by health care professionals.

Previously, lottery revenues were earmarked for deposit in economic development, local transportation assistance and two state heritage funds. Under Proposition 203, the $17 million will be distributed only after the economic development, local transportation assistance and heritage funds receive their full appropriations.

CA **1996 Cal. Stats., Chap. 13 (SB 668)** expands the scope of practice of optometrists to use therapeutic pharmaceutical agents and provide for diagnosis and treatment of specified conditions or diseases of the human eye or its appendages.

CA **1996 Cal. Stats., Chap. 148 (AB 3007)** allows private, nonprofit hospitals in certain counties to enter into joint powers of agreement with public agencies to provide public health care services.

CA **1996 Cal. Stats., Chap. 158 (SB 1738)** allows certified nurse-midwives to perform episiotomies and repair first-degree and second-degree lacerations of the perineum in licensed acute care hospitals and alternate birth centers if certain conditions are met.

CA **1996 Cal. Stats., Chap. 455 (AB 1077)** authorizes certified nurse practitioners to furnish a broader range of drugs and devices, including specified controlled substances, pursuant to standardized procedures and protocols, to a broader range of patients and in additional practice settings.

CA **1996 Cal. Stats., Chap. 527 (SB 1596)** allows health care plans and health insurers to pay for or reimburse the cost of services provided by pharmacists.

CA **1996 Cal. Stats., Chap. 533 (SB 1798)** permits medical groups and independent practice associations contracting with health plans to contract with licensed nonphysician providers. The act permits the nonphysician providers to bill the health plan directly for services and to be listed in plan directories.

CA **1996 Cal. Stats., Chap. 817 (AB 2443)** revises the Physician Ownership and Referral Act of 1993 to provide additional exemptions from the current prohibition against certain health care referrals by health care licensees who have a defined financial interest in the person or entity receiving a referral.

CA **1996 Cal. Stats., Chap. 902 (SB 2098)** authorizes the Medical Board of California to develop a proposed registration program that would permit physicians, surgeons and podiatrists located outside the state to practice medicine across state lines and requires them to meet the legal requirements of the state.

CA **1996 Cal. Stats., Chap. 1012 (AB 2577)** allows San Luis Obispo County to close its county hospital emergency room and contract with non-county hospitals for emergency room services without risk of losing state funding for indigent health care.

CA **1996 Cal. Stats., Chap. 1089 (AB 3013)** prohibits health care service plans from contractually limiting a physician or other licensed health care provider from fully advising patients about treatment options.

CA **1996 Cal. Stats., Chap. 1094 (SB 1805)** makes violations of existing law protecting health care practitioners, physicians, or surgeons who advocate for appropriate health care on a patient's behalf subject to the criminal sentences provided by the Knox-Keene Health Care Service Plan Act of 1975.

CO **1996 Colo. Sess. Laws, Chap. 103 (SB 49)** requires direct-entry midwives to disclose if they have no liability insurance. The law also adds to the acts and omissions that are grounds for disciplining direct-entry midwives and sets forth other requirements regarding the profession.

CO **1996 Colo. Sess. Laws, Chap. 153 (HB 1082)** prohibits the issuance or renewal of a managed care plan that provides coverage for reproductive health or gynecological care unless the plan either provides a woman direct access to an obstetrician or gynecologist participating and available under the plan or establishes procedures to ensure that, upon a woman's timely request for a referral to such a physician, the request is not unreasonably withheld.

CO **1996 Colo. Sess. Laws, Chap. 300 (SB 100)** allows nonprofit hospital, medical-surgical and health service corporations to elect to convert to a stock insurance company under a complying plan. The law also provides for the transfer of the fair market value of the nonprofit hospital, medical-surgical and health service corporation to a qualifying entity, defined as an independent tax-exempt charitable or social welfare organization.

CT **1996 Conn. Acts, P.A. 96-19 (HB 5023)** allows advanced practice registered nurses (APRNs), nurse-midwives and physician assistants, in addition to physicians and osteopaths, to sign a statement for purposes of marriage licenses issued by town registrars of vital statistics that an individual has undergone a standard blood test; if the test was positive, had a physical exam; and, in their opinion, is not infected with syphilis or in a communicable stage of that disease. The act allows these three practitioners to sign a statement that a female marriage license applicant under age 50 and capable of conceiving has undergone a rubella immunity test. The practitioners must disclose results of the test in writing to the applicant. The act also makes technical changes to reflect the existing prescriptive authority of APRNs and physician assistants.

CT **1996 Conn. Acts, P.A. 96-227 (HB 5364)** extends to subscribers of health care centers, including HMOs, the requirement that women have direct access to network obstetricians or gynecologists for certain services.

DE **Vol. 70 Del. Laws, Chap. 516 (SB 418)** reauthorizes the Delaware Institute of Medical Education and Research (DIMER) by reconstituting it as an advisory board to the Delaware Health Care Commission. The act expands representation on the DIMER board, emphasizes DIMER's statewide responsibilities and expands its purpose to help the state meet its health care needs. The act requests that the board look at expanding of opportunities to training at a reasonable cost in the health and health-related professions when state residents commit to practice their professions in Delaware, offering incentives for qualified personnel in the health and health-related professions to practice in Delaware and continuing to develop a coordinated program of premedical, medical and graduate education among state public institutions of higher learning, Delaware hospitals and Jefferson Medical College. The board is encouraged to support graduate and post-graduate medical and health care training programs, including emphasis on those programs targeted to meet the state's health care needs and programs of education, training and research in the health fields, including the vital areas of public health education, community health planning and health care costs. The act gives the board the responsibility for developing a recruitment program for medical education in conjunction with local colleges and universities to encourage medical school applications from minorities and residents of rural counties and underserved areas of Delaware, in addition to other students interested in pursuing a medical education.

FL **1996 Fla. Laws, Chap. 147 (SB 112)** requires that osteopathic physicians be accorded equal professional status and privileges as other physicians. The act prohibits certain health-related entities from discriminating against a licensee on the basis of licensure.

FL **1996 Fla. Laws, Chap. 197 (HB 495)** requires third-party payers to reimburse employers of physician assistants (PAs) for covered services. A supervisory physician may grant a PA the authority to prescribe drugs as long as the medication is listed in the formulary under specified circumstances and specified information is contained on the prescription.

FL **1996 Fla. Laws, Chap. 274 (HB 581)** revises various certification requirements for advanced registered nurse practitioners and authorizes them to order diagnostic tests and physical and occupational therapy under certain circumstances. The act directs the Agency for Health Care Administration to establish a task force to evaluate the current prohibition on the prescription authority of controlled substances by advanced registered nurse practitioners. The act also directs the agency to establish a task force representative of the agency's Divisions of Medical Quality Assurance, Health Quality Assurance and Health Policy and Cost Control; the Board of Nursing; and the Florida Nurses Association to determine the effect of the number of licensed nurses and the skill mix of licensed, technical and nonlicensed nursing staff on services, including, but not limited to, quality of services, length of stay, patient accidents, medication errors and delays in surgical procedures. The task force must report its findings by December 31, 1997.

FL **1996 Fla. Laws, Chap. 279 (HB 1239)** prohibits an HMO from discriminating against or failing to contract with a hospital, based solely on the fact that the hospital's medical staff is comprised of osteopathic physicians. Nothing in the act mandates that an HMO contract with a hospital.

FL **1996 Fla. Laws, Chap. 296 (HB 537)** revises the regulations and licensure procedures for chiropractors. The act revises the definition of chiropractic to authorize the ordering, storing and administering of prescription medical oxygen and certain topical anesthetics in aerosol form under emergency circumstances only. The act also revises the ground rules related to the prescribing, dispensing and administering of medicinal drugs and the keeping of written chiropractic records.

FL **1996 Fla. Laws, Chap. 304 (HB 965)** gives any county, district, or municipal hospital the authority to sell or lease the hospital to a for-profit or not-for-profit Florida corporation and enter into leases or other contracts with a for-profit or not-for-profit Florida corporation for the purpose of operating and managing the hospital and its facilities. The governing board of the hospital must find that the sale, lease, or contract is in the best interests of the public and must state the basis of the finding.

FL **1996 Fla. Laws, Chap. 403 (HB 555)** authorizes the Department of Health (DOH) to establish uniform application forms and certificates of licensure for use by the boards within the department. Each board with five or more members is required to have at least two consumer members who are not and have never been, members of the profession regulated by the board. Boards with fewer than five members must have at least one consumer member outside of the profession.

Finally, the act creates a task force to make recommendations on the structure and organization of publicly funded health-related programs and agencies; the organizational placement of health facility and health care practitioner regulation that will ensure the highest quality of health care; the role and mission of local and state agencies with public health care functions; methods for coordinating health services delivery with health care financing, policy, purchasing and regulatory requirements; and the advantages and disadvantages of centralizing health care administration and accountability. A report is due to the governor and Legislature by December 31, 1996. (See "Access and Reform" and "Coordination" for more information.)

GA **1996 Ga. Laws, p. 751 (H 1338)** enacts the Patient Protection Act, with provisions for the certification and regulation of managed health care plans by the commissioner of insurance. Among other provisions, the act uses the prudent layperson test to define emergency care services as services that are provided for a condition of recent onset and sufficient severity, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The act specifies that prior authorization is not required for the reimbursement of these services. (See "Insurance and Managed Care" and "Providers" for more information.)

GA **1996 Ga. Laws, p. 820 (S 592)** allows an insured woman to see an obstetrician or gynecologist who is one of the health plan's network providers without first obtaining a referral, provided that the services are limited to those defined by the Accreditation Council For Graduate Medical Education for training as an OB/GYN, including but not limited to diagnosis, treatment and referral. Each health benefit policy must disclose to its insureds in clear, accurate language, a person's right to direct access to obstetricians and gynecologists at the time of enrollment and at least annually thereafter.

GU **1996 Guam Laws, P.L. 23-9** allows optometrists independent use of certain therapeutic pharmaceutical agents as topical preparations and use of additional oral and topical agents under a co-management arrangement with an ophthalmologist.

GU **1996 Guam Laws, P.L. 23-123** requires pharmacies to provide written information for each initial prescription filled by a pharmacy, medical clinic or doctor, giving the name of the drug, the ailment being treated, contraindications, interactions and a list of the most common side effects.

HI **1996 Hawaii Sess. Laws, Act 150 (SB 2532)** ensures that recipients of health care services are not misguided by the titles of certain providers by allowing only registered nurses, licensed practical nurses and advance practice registered nurses to assume the title of nurse.

HI **1996 Hawaii Sess. Laws, Act 262 (SB 2522)** recognizes the dynamic environment in which community hospitals must operate and the need for quick response and an ability to function in a manner that is free from routine state restrictions by creating a public corporation with an independent board of trustees as a structure for the governance of the hospitals.

HI **1996 Hawaii Sess. Laws, Act 263 (SB 3198)** provides for the transfer of the Hana medical center from the state to a Hana nonprofit health care organization to promote a community-based health program. The act requires the Department of Health to report back to the Legislature.

HI **1996 Hawaii Sess. Laws, Act 292 (HB 2647)** increases accessibility to certain kinds of health care for the eye while maintaining standards of care by authorizing the Board of Examiners in Optometry to certify qualified optometrists to use and prescribe topical therapeutic pharmaceutical agents determined by a committee of health care professionals.

ID **Idaho Const. Amend. (Leg. Ref., SRJ 111), 1996 Gen. Election** allows Idaho's county, district and joint city/county hospitals to engage in shared services and other joint or cooperative ventures, to enter into joint ventures and partnerships to finance facilities and projects and to participate in other sharing arrangements necessary to provide health care services. The amendment clarifies the ability of public hospitals to enter into cooperative and collaborative efforts by exempting public hospitals from the prohibition against the lending of credit and risk-sharing by state and local government entities contained in the constitution of the state of Idaho.

IL **1996 Ill. Laws, P.A. 89-373 (SB 1246)** requires health or accident insurers and managed care plans that require an insured to designate a gatekeeper to coordinate care or control access to health care services to also allow female insureds to designate a woman's principal health care provider. This provider must be a licensed physician specializing in obstetrics and gynecology. Insureds designating a woman's principal health care provider must be given direct access to that provider for covered services or treatment without the need for referral or prior approval.

IL **1996 Ill. Laws, P.A. 89-506 (HB 22)** creates a Medical Research and Development Fund and a Post-Tertiary Clinical Services Fund, which may receive state appropriations. The first fund is to match federal and private aid for biomedical research, technology and program development at large academic medical centers in the Chicago area and at the SIU School of Medicine and its affiliated teaching hospitals in Springfield. The second fund is to pay subsidies to those hospitals and to the University of Illinois' primary teaching hospitals in Peoria and Rockford, to promote any of 15 kinds of medical therapies or diagnostic methods.

IL **1996 Ill. Laws, P.A. 89-607 (HB 3618)** creates a single Good Samaritan Act, replacing Good Samaritan immunity provisions for the following: people certified in basic CPR; dentists; physicians; nurses; physical therapists; podiatrists; respiratory care practitioners; veterinarians; police officers;

firemen; free dental and medical clinics; those aiding choking victims; emergency telephone systems personnel giving instructions to callers; and employers and employees under the Health and Safety Act.

IN **1996 Ind. Acts, P.L. 192 (SB 392)** provides that an agreement between an insurer or a health maintenance organization and a health care provider may not prohibit the disclosure of certain financial or treatment information. The act also provides that a health insurance policy may not require an insured to seek a referral from a primary care provider in order to obtain services related to women's health from certain providers. An insurer also may not prohibit a provider who primarily provides women's health services from serving as a primary care provider if the provider meets certain standards and requests designation as a primary care provider.

IN **1996 Ind. Acts, P.L. 219 (SB 176)** provides that an individual who gratuitously supplies medical care at the scene of an emergency or accident is immune from civil liability for any personal injury that results from the care provided except in cases of gross negligence or willful or wanton misconduct.

IA **1996 Iowa Acts, Chap. 1128 (SF 2171)** deletes a requirement that applicants for loan repayment or scholarship programs, pursuant to primary care provider recruitment and retention endeavor (PRIMECARRE), commit to a minimum service obligation of 10 years and instead requires a year of service for each year of loan repayment, unless federal requirements require otherwise.

IA **1996 Iowa Acts, Chap. 1158 (SF 2157)** amends the duties of the college student aid commission in administering the Iowa Guaranteed Loan Program. Of the money loaned to an eligible student, for each year of up to and including four years of practice in Iowa, an amount equal to 25 percent of the original principal and the proportionate share of accrued interest, or $1,100, whichever is greater, shall be forgiven. The act also creates a chiropractic loan revolving fund for the Chiropractic Graduate Student Forgivable Loan Program. It also modifies the registration requirements for postsecondary schools and increases registration fees.

KS **1996 Kan. Sess. Laws, Chap. 91 (HB 2867)** amends existing law to add registered physician's assistants to the definition of a charitable health care provider.

KS **1996 Kan. Sess. Laws, Chap. 169 (SB 477)** amends the terms "individual practice association" and "medical group" or "staff model" to include surgeons and other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists.

KS **1996 Kan. Sess. Laws, Chap. 179 (SB 152)** adds to the duties that a registered nurse anesthetist may perform under order of a physician or dentist, including developing a general plan of anesthesia care, selecting the method for administration of anesthesia or analgesia, selecting appropriate medications and anesthetic agents and inducing and maintaining anesthesia or analgesia at the required levels.

KS **1996 Kan. Sess. Laws, Chap. 210 (SB 625)** allows a not-for-profit corporation that is also a medical care facility, an indigent health care clinic, a federally qualified health center, or a local health department to enter into a contract or to employ a licensed dentist to provide dental services to people who are indigent and do not have health insurance, people who are eligible for Medicaid, or people who are qualified for Indian Health Services. A dentist who provides services for the dentally indigent is immune from liability. The act also provides that a dentist who is classified as retired by the board is not required to pay an annual license renewal fee or meet continuing education requirements if the dentist elects to provide dental services to the dentally indigent through one of the entities set out in this act. The provisions of the act expire on July 1, 1998.

KY **1996 Ky. Acts, Chap. 26 (HB 363)** amends the membership to the Kentucky Nursing Incentive Scholarship Fund Committee. Preference in funding will no longer be required to be given to applicants who have agreed to work in hospitals, nursing facilities, skilled nursing facilities, intermediate care facilities, or primary care centers in rural areas of the state. However, each recipient of a scholarship shall agree in the written contract to practice as a nurse in Kentucky for at least one year for each academic year funded. The act deletes a provision that calls for matching funds by a sponsoring health facility or educational institution participating as an applicant's sponsor in the Kentucky Nursing Incentive Scholarship Fund Program.

The act also allows the Board of Nursing to establish an impaired nurses committee to promote the early identification, intervention, treatment and rehabilitation of nurses who may be impaired by reason of illness, alcohol or drug abuse, or as a result of any physical or mental condition. Beginning January 1, 1997, the board shall collect an assessment of $5 to be added to each nurse licensure renewal application fee payable to the board, proceeds from which shall be expended on the operation of an impaired nurses committee.

KY **1996 Ky. Acts, Chap. 110 (HB 397)** phases out the provider tax on physicians by June 30, 1999.

KY **1996 Ky. Acts, Chap. 187 (HB 782)** requires health insurance policies to guarantee that covered people will have direct access to the primary chiropractic provider of their choice without referral from another provider.

KY **1996 Ky. Acts, Chap. 304 (HB 494)** permits payments under the Medical Assistance Program for services which are within the lawful scope of practice of a chiropractor to the extent the Medical Assistance Program pays for the same services provided by a physician.

KY **1996 Ky. Acts, Chap. 342 (HB 358)** authorizes advanced registered nurse practitioners to prescribe legend drugs under certain conditions, requires continuing education in pharmacology and requires written collaborative agreements with physicians.

KY **1996 Ky. Acts, Chap. 348 (SB 400)** requires insurers offering medical professional liability insurance to make available the same coverage for charitable health care providers that it offers to noncharitable health care providers.

KY **1996 Ky. Acts, Chap. 371 (SB 343)** makes numerous changes to the comprehensive health reform legislation enacted in 1994. The act limits mandated data submission to that collected on the uniform health insurance claim form and repeals the requirements that providers, hospitals and facilities conspicuously post maximum fees charged. The act repeals the requirement relating to the development, updating and implementation of parameters for clinical practice for use by health care providers. The act raises the expenditure threshold for major medical equipment from $500,000 to $1.5 million before a certificate of need is required for a physician's office. (See "Medicaid," "Access and Reform," and "Insurance and Managed Care" for more information.)

ME **1996 Maine Laws, Chap. 606 (LD 1814)** creates a glaucoma consultation subcommittee comprised of two optometrists and two physicians to review the glaucoma-related consultation requirements and creates a new license category for optometrists known as the "advanced therapeutic license" and sets forth the educational and consultative requirements of that license. Advanced therapeutic licensees may treat glaucoma and prescribe oral medications to treat ocular diseases other than glaucoma. Current therapeutic licensees must upgrade their licenses to advanced therapeutic licenses within three years.

ME **1996 Maine Laws, Chap. 617 (LD 1385)** requires all health plans to cover pap tests recommended by a physician, with a few exceptions for limited coverage plans. A managed care plan must permit a physician who specialized in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the organization's credentialling policy. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner, or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. If the examination reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner, or certified nurse midwife to secure from the patient's primary care physician a referral to the participating provider from whom such care may be obtained. This act does not prohibit a carrier from requiring a participating physician, certified nurse practitioner, or certified nurse midwife to inform a woman's primary care physician before each treatment.

ME **1996 Maine Laws, Chap. 653 (LD 1788)** creates the Maine Health Data Organization (MHDO) to continue the data collection efforts of the Maine Health Care Finance Commission, which expired on June 30, 1996. The act provides for the establishment and duties of the MHDO governing board, with board members representing consumers, employers, payers and providers.

The act directs the board to establish uniform reporting systems. The board must develop and implement data collection policies and procedures for collecting, processing, storaging and analyzing clinical, financial and restructuring data. The act directs the board to integrate data systems, standardize concepts and coordinate the development of a linked public and private sector information system. The board must emphasize data that are relevant and not duplicative of existing data and minimize the burden on those providing data. In addition, the board is directed to preserve the accuracy of collected data while ensuring that the data are available in the public domain.

The act retains current requirements for information to be submitted by facilities, providers and payers. Each health care facility must file with the organization scope of service information and a completed uniform hospital discharge data set, or comparable information, for each patient discharge from the facility, for each major ambulatory service listed in rules adopted by the organization and for each hospital outpatient service. Each health care facility must file with the organization financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges and units of services. The act provides for confidentiality, use of data for research purposes and access to aggregate data.

To finance the Maine Health Data Organization during the transition, the act allows all hospitals except state hospitals to be assessed not more than .07 percent of their gross patient revenues, not to exceed $775,000 for all hospitals. Each hospital must pay the assessment quarterly. The act requires the board to submit legislation to establish fees and assessments for permanent funding.

In order to conduct quality improvement research, the board is authorized to designate a quality improvement foundation if the board finds that the foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and has protocols to safeguard confidential and privileged information.

The act amends and reenacts provisions governing comprehensive health planning. The act requires that the Department of Health adopt a state health plan before January 15, 1997 and review it every year after 1997. The plan must identify the state's health care, facility and human resource needs, the resources available to meet those needs and recommendations for addressing those needs statewide.

The act directs the Department of Health to adopt reasonable charity care guidelines for hospitals. The department must adopt income guidelines that are consistent with the guidelines applicable to the federal Hill-Burton Program. The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. The guidelines must include provisions for notice to the public and the opportunity for a fair hearing regarding eligibility for charity care.

The act directs the Department of Health to convene at least once annually a health workforce forum to discuss health workforce issues. The forum must include representatives of health professionals, licensing boards and health education programs. The act directs the forum to develop an inventory of present health workforce and educational programs and to develop research and analytical methods for understanding population-based health care needs on an ongoing basis. Through the forum, the department is to serve as a clearinghouse for information relating to health

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workforce issues. The department will use the information gathered through the forum to make its health policy and planning decisions.

ME **1996 Maine Laws, Chap. 671 (LD 1852)** establishes the Board of Complementary Health Care Providers to regulate the practice of naturopathic doctors and acupuncturists. The act allows naturopathic doctors to prescribe nonprescription medications without limitation and to prescribe those noncontrolled legend drugs that the doctor judges are consistent with the doctor's education and training. The board may further restrict naturopathic doctors' prescriptive authority regarding noncontrolled legend drugs by rule. Before independently prescribing noncontrolled legend drugs, a naturopathic doctor must establish and complete a 12-month collaborative relationship with a licensed allopathic or osteopathic physician to review the naturopathic doctor's prescribing practices. The act forbids a naturopathic doctor from prescribing, dispensing, or administering any substance or device identified in Schedules I-V or any controlled substances or devices. A naturopathic doctor is not allowed to perform surgical procedures or practice emergency medicine except for the care of minor injuries as a good Samaritan rendering gratuitous services in the case of emergency, nor practice or claim to practice medicine and surgery, osteopathy, dentistry, podiatry, optometry, chiropractic, physical therapy, or any other system or method of treatment not authorized in this act.

MD **1996 Md. Laws, Chap. 14 (SB 68)** allows the Board of Physician Quality Assurance to waive certain examination requirements for applicants for a state license to practice medicine who are licensed by the Medical Council of Canada.

MD **1996 Md. Laws, Chap. 365 (SB 59)** requires each hospital to offer mammography educational materials to each female patient when medically appropriate for the patient. The Department of Health and Mental Hygiene, in collaboration with specified entities, must select and approve or develop and print and update as necessary, the materials.

MD **1996 Md. Laws, Chap. 503 (HB 859)** requires HMOs to reimburse hospital emergency facilities and providers (minus the applicable copayment) for medically necessary services provided to an HMO enrollee, if the HMO authorized, directed, referred, or allowed the use of the emergency facility and the services are related to the condition for which the member was allowed to use the emergency facility. The act stipulates that a provider is not required to obtain prior authorization or approval for payment from an HMO in order to obtain reimbursement. The act authorizes the hospital, provider, or insurer that has reimbursed a provider to collect or attempt to collect payment from an enrollee for a medical condition that is determined not to be an emergency.

The act requires HMOs to provide to members a statement of the potential responsibility of the member to pay for services the member seeks to obtain from a provider, including a physician or hospital, that does not have a written contract with the HMO. In addition, HMOs must provide members with a description of procedures to be followed for emergency services, including: the appropriate use of hospital emergency facilities, the appropriate use, location and hours of operation of any urgent care facilities operated by the HMO and the potential responsibility of subscribers and enrollees for payment for emergency services or nonemergency services rendered in a hospital emergency facility.

MD **1996 Md. Laws, Chap. 529 (HB 1207)** requires the secretary of health and mental hygiene to adopt regulations for a primary source verification system. Primary source verification is the process used to ensure the truth and accuracy of documents and information submitted by a physician who is applying for practice privileges, entering into a contract, or seeking employment with a hospital, HMO, or other health care facility. (See "Insurance and Managed Care" for more information.)

MD **1996 Md. Laws, Chap. 549 (HB 1390)** requires the Health Resources Planning Commission, in consultation with the Department of Health and Mental Hygiene and the Health Services Cost Review commission, to assess the current availability and accessibility of primary care services necessary to serve the Medicaid population and the uninsured and the ability of education programs in primary care specialties, including medical residencies, to provide clinical training sites. The act also directs the commission to examine the utilization and reimbursement levels between managed care organizations and ancillary providers of health care services to determine the impact on access to quality medical care. A report on the results of the commission's investigation, together with any resulting policy recommendations, is due on or before November 1, 1996.

MD **1996 Md. Laws, Chaps. 579 and 580 (SB 392/HB 863)** amends current law that requires any health plan that provides hospital, medical, or surgical benefits on an expense-incurred basis to classify an OB/GYN as a primary care physician or allow an annual visit to an OB/GYN without a referral from a primary care physician. The act specifies that if the OB/GYN chooses not to be a primary care physician, a woman may receive gynecological care from an in-network OB/GYN without first visiting a primary care physician provided that the care is medically necessary, including, but not limited to, routine care. Following each visit for gynecological care, the OB/GYN must communicate with the woman's primary care physician concerning any diagnosis or treatment rendered.

MA **1996 Mass. Acts, Chap. 307 (HB 5662)** requires the Board of Registration in Medicine to create a clinical quality improvement unit to identify cases that appear to involve substandard care and develop procedures for investigation and possible disciplinary action. The act requires the board to create a voluntary remediation program designed to improve physicians' clinical and communication skills, to be offered as an alternative to disciplinary action.

The act allows the board to create individual provider profiles and disseminate them to the public. The act specifies what information should be included in the profiles. The act requires that providers be given the chance to review their profile before publication and make corrections and additions.

For any reports that compare individual health care providers, the act requires that those providers be meaningfully involved in the development of all aspects of the profile methodology. The limitations of the data sources and analytic methodologies used to develop provider profiles must be clearly identified. Comparisons among provider profiles must adjust for patient case-mix and other relevant risk factors. The act requires safeguards to protect against the unauthorized use or disclosure of provider profiles and the dissemination of faulty data. The quality and accuracy of provider profiles, data sources and methodologies must be evaluated regularly. The act requires providers to be reimbursed for the reasonable costs required for providing the necessary data. Finally, the act allows the board to disseminate physician profiles by electronic media, including the World Wide Web or on CD-ROM after May 1, 1997. The board must conduct a study on the impact of publication of physician profiles by electronic media.

MI **1996 Mich. Pub. Acts, Act 355 (S 432)** provides that a physician who is a sole practitioner or who practices in a group of physicians and treats patients on an outpatient basis may not supervise more than four physician's assistants. If the physician supervises physician's assistants at more than one practice site, the physician may not supervise more than two physician's assistants by a method other than the physician's actual physical presence at the practice site. A supervising physician may delegate to a physician's assistant the ordering, receipt and dispensing of complimentary starter dose drugs other than the specified controlled drugs as defined by law. A physician also may delegate in writing to a registered professional nurse the ordering, receipt and dispensing of complimentary starter dose drugs other than the specific controlled drugs defined by law.

MN **1996 Minn. Laws, Chap. 318 (HF 2558)** allows a nurse to perform medical care procedures at the direction of a doctor, podiatrist, or dentist licensed in another state, U.S. territory, or Canadian province if that doctor, podiatrist, or dentist has examined the patient in the doctor's home state.

MN **1996 Minn. Laws, Chap. 395 (SF 2849)** provides $14.4 million for higher education spending including $6.6 million to restructure the University of Minnesota academic health center, improve technology and update the curriculum. Ninety percent of the academic health center appropriation--about $5.9 million--is contingent upon making changes to the personnel policies in the center. The act requests that the school pursue changes in the tenure code for the academic health center without infringing on academic freedom. The remaining 10 percent of the $6.6 million for the academic health center is earmarked for the University of Minnesota-Duluth (UMD) medical school. The money hinges on the continued development of the medical school as a rural health center, which aims to produce more medical professionals to serve rural areas. Another $2 million in the act will be used for interactive communications technology to link academic health center facilities in Minneapolis, St. Paul and Duluth and other community-based sites. Most of the remaining money will be used to bolster technology at the state's higher education institutions.

MS **1996 Miss. Laws, Chap. 496 (H 1187)** amends current law to specify that all University of Mississippi Medical Center locations provide not less than 50 percent of their services to indigent people, including qualified beneficiaries of the state Medicaid program. The act also authorizes the teaching hospital and related facilities to establish and operate managed care plans and to enter into group purchasing arrangements.

MO **1996 Mo. Laws, p. 701(HB 999)** establishes new requirements for the certification of physician assistants. Except for individuals certified and practicing three years before August 28, 1989, physician assistants must graduate from an accredited physician assistant program and pass the national certification examination. Constant physical presence of the supervising physician is not required as long as the physician can easily be contacted by a telecommunications device. Physicians must be available for on-site review of work, records and practice at least once every two weeks, except in extended care facilities, where reviews will be conducted at least once a month. The Board of Healing Arts is required to develop rules for supervising the physician and physician assistant. The act also establishes a designated fund within the Board of Healing Arts Fund and creates an advisory commission for registered physician assistants.

NE **1996 Neb. Laws, L.B. 414** adopts the Advanced Registered Nurse Practitioner Act. The act makes a number of changes relating to nurse practitioners and changes the statutory references for nurse practitioners to "advanced registered nurse practitioners." With some exceptions, advanced registered nurse practitioners are required to sign a written agreement, called an integrated practice agreement, with a physician. The agreement defines their collaborative relationship for providing health care. Additionally, an advanced registered nurse practitioner who has less than 2,000 hours of supervised practice must work under protocols designed to guide the advanced registered nurse practitioner's practice. The act requires that any patient with a condition beyond an advanced registered nurse practitioner's scope of practice must be referred to a physician or other health care practitioner. The advanced registered nurse practitioner may refer patients to providers other than the one with whom he or she has an integrated practice agreement.

NE **1996 Neb. Laws, L.B. 1155** changes the definition of health clinic to exempt facilities that provide only routine health screening, health education and immunizations from licensing requirements. The act also provides that health care practitioners who relocate into a health professional shortage area can qualify for the state loan repayment program.

NE **1996 Neb. Laws, L.B. 1188** requires the Department of Health to approve or disapprove any proposed acquisition of a hospital by a for-profit hospital or other group."Acquisition" is defined as a transaction that results in a change of at least 20 percent of the ownership or controlling interest in a hospital or that results in the acquiring party owning or controlling at least 50 percent of the hospital. The act provides that all documents related to the application for acquisition be public records. Public notice of the application in a newspaper and a public hearing are also mandated.

The act also requires notification to the attorney general of a proposed nonprofit hospital sale by a for-profit entity and the attorney general may, but is not required to, review and approve or disapprove the proposal. The decision by the Department of Health and attorney general if applicable, must be made within 60 days after receipt of the acquisition application. If the two nonprofit entities have substantially similar charitable health care purposes, a transfer between two nonprofit hospitals is exempt from state review.

NH **1996 N.H. Laws, Chap. 81 (HB 1509)** makes certain retired physicians immune from civil liability for volunteer health education services when providing education in good faith, without compensation in public forums or in responses to individual inquiries from members of the public.

Education does not include advice given to individual members of the public in the nature of diagnosis or treatment.

NH **1996 N.H. Laws, Chap. 110 (HB 1586)** requires the post-secondary education commission to adopt rules that require post-secondary institutions that participate in certain federal loan Programs to reimburse the state for their proportionate share of any default cost fees. The act also allows part-time nursing service to be prorated to meet the full-time nursing service requirement for cancellation of nursing scholarship loan obligations.

NH **1996 N.H. Laws, Chap. 146 (HB 1306)** exempts community health clinics under the state licensure law.

NH **1996 N.H. Laws, Chap. 277 (SB 599)** adds physician assistants and advanced registered nurse practitioners as individuals who may perform physical examinations of pupils. The act authorizes school nurses to possess and administer, with written parental authorization, certain drugs for disease prevention and emergency treatment, setting forth the duties of school nurses in the control and prevention of communicable disease.

NH **1996 N.H. Laws, Chap. 299 (SB 4)** establishes a two-year pilot program relative to ambulatory surgical facilities. During the pilot program period, an ambulatory surgical facility licensed on or before July 1, 1996, may provide two beds for overnight accommodation of patients. The commissioner of health and human services is directed to adopt rules regarding the pilot program.

NJ **1996 N.J. Laws, Chap. 28 (AB 1532)** provides $310 million for indigent care payments to hospitals for 1996 and $300 million in 1997, down from $400 million that was available in 1995. Funds still will be used from the unemployment fund. The law also authorizes the commissioner of the Department of Health to submit a waiver to the federal government in order to allow New Jersey to use disproportionate share payments for a managed care plan for charity care. The law also funds the hospital health care subsidy account that provides payments to hospitals that treat a large amount of AIDS, TB, low-birthweight babies, drug and alcohol abuse and other public health problems. The subsidy account is funded at the same level as the last two years.

NM **1996 N.M. Laws, Sen. Jt. Mem. 36** requests that the New Mexico Health Policy Commission, in cooperation with publicly funded post-secondary educational institutions training health professionals, convene a task force to develop options that address the supply and distribution of the state's health professional work force. The commission is asked to report to the appropriate interim legislative health care committee by October 15, 1996.

NM **1996 N.M. Laws, Sen. Jt. Mem. 63** requests the creation of a task force to study mandatory training and education of health care providers on HIV and other infectious diseases and the laws relative to their treatment.

NY **1996 N.Y. Laws, Chap. 253 (S 7537-A)** indefinitely continues the child health insurance program (Child Health Plus) and the regional pilot projects for the uninsured by removing the sunset date of June 30, 1996 for each program. The act authorizes the continuation and amendment of any contractual arrangements with approved organizations to provide coverage for eligible individuals in effect on that date in order to provide an uninterrupted continuation of services. The act stipulates, however, that these programs will remain in effect only as long as funds continue to be available.

The act makes available to the commissioner of health, for distribution to these two programs, funds accumulated in pool reserves for regional or statewide pools, as well as certain funds accumulated in the health care planning account during the period January 1, 1996, to June 30, 1996. The act authorizes the commissioner, for cash flow purposes, to allocate funds accumulated for distribution from certain other specified pools to the pool reserves in order to pay the premiums for the continuation of Child Health Plus and the regional pilot projects and requires the commissioner to refund this money when pool reserve funds become available. Finally, the act extends for another year, until June 30, 1997, the excess medical malpractice liability insurance program (see Chap. 639 for other information related to the Child Health Plus Program).

NY **1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)** enact the "New York Health Care Reform Act of 1996," which continues only until December 31, 1996, existing provisions of the state's hospital reimbursement rate-setting law. The acts continue beyond 1996 until December 31, 1999, the same rate-setting methodology only for Medicaid and certain other payers. The acts deregulate the payment system for most other payers, on and after January 1, 1997, by allowing them to negotiate with hospitals to establish their own payment rates.

The acts establish a number of new provisions for the financing of "public goods programs" on and after January 1, 1997. Insurers and other payers must pay allowances on payments for services rendered, as well as per-person payments for each individual or family member covered by the insurer ("covered lives assessments"), which go into a pool to fund the public goods programs. Funds from these payments, as well as certain Medicaid funds and other payments, are used to finance the costs of graduate medical education, various insurance programs for the uninsured, primary care development, emergency medical services training and health facility restructuring and provider networking programs designed to assist providers in adapting to the changing health care environment.

For example, the acts authorize the commissioner of health to distribute funds in the health care initiatives pool for the Child Health Plus Program ($120 million in 1997, $164 million in 1998 and $181 million in 1999), the Small Business Health Insurance Partnership Program, the Voucher Insurance Program, the Individual Subsidy Program, the Catastrophic Health Care Expense Program, the Primary Health Care Services Pool and the Primary Care Education and Training Program (including the loans, scholarships and medical education grants for minority participation).

The acts continue and expand the Primary Care Physician Loan Repayment Program and add to the eligibility requirements for residents that they must agree to practice in underserved areas. The acts also enhance the program's efforts to encourage minority participation in medical education.

The acts create a new State Task Force on Health Care Quality Improvement and Information Systems within the Department of Health and authorize the commissioner of health to award grants to support collaborative community-based efforts to improve health status and quality of care.

The acts make permanent the Child Health Plus Program, through which primary and preventive health services are provided to eligible children, expand the program by increasing the age limit for eligibility, add coverage for hospital and related inpatient services and make several other changes. Participating insurers must impose a copayment of $2 per visit for physician services, in addition to the other copayments and coinsurances for which insurers are permitted to require payment.

The acts make numerous changes to New York's rural health act and rename it the "Access to Community Health Services in Rural Areas" act. The acts establish a new Title II, comprising provisions for the designation of primary care hospitals and creating a new "Rural Health Care Access Development Program." The commissioner may develop guidelines for consideration of a request from a general hospital to be designated a "primary care hospital," allowing the facility to be exempt from particular services or authorized to offer additional special services. The acts revise the definition of a "rural health network" to allow a not-for-profit corporation to organize a network and to expand the types of health care services that may be included in a network arrangement. The acts allow Rural Health Network Development Grants to be used to support activities and organizational costs, including the recruitment of qualified health care professionals, the development of affiliation agreements among rural health providers, the development of managed care capacities, the expansion and integration of public and preventive health services into community-based primary care systems and the integration and expansion of prehospital emergency medical services. The acts create a new "Rural Health Care Access Development Program," through which grants and financial assistance can be provided to general hospitals classified as rural

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hospitals under federal or state regulations, in recognition of the unique costs incurred by these facilities in providing hospital services in remote or sparsely populated areas. The acts require each hospital to annually prepare and make available to the public an implementation report regarding the hospital's performance in meeting the health care needs of the community, providing charity care services and improving access to health care services by the underserved.

NC **1996 N.C. Sess. Laws, Chap. 634 (HB 1149)** allows the North Carolina Medical board to issue to an applicant a special license called a "Limited Volunteer License," authorizing the holder to practice medicine and surgery only at clinics which specialize in the treatment of indigent patients. The holder of a limited license may not receive compensation for services rendered at these clinics. The applicant must have a medical license from another state and produce a letter from that state indicating that the applicant is in good standing and is authorized to treat United States armed forces personnel or veterans.

NC **1996 N.C. Sess. Laws, Chap. 713 (SB 855)** authorizes public hospitals to acquire an ownership interest in a managed care company with which the public hospital is also directly or indirectly a contracting provider. The act also makes confidential any financial information related to the provision of health care between a hospital and a managed care organization, insurance company, employer, or other payer. This provision expires June 1, 1997.

NC **1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part XVI (SB 46, Part XVI)** abolishes the North Carolina Health Care Reform Commission, effective January 1, 1997. The act also requires every occupational licensing board that has authority to license physicians, physician assistants, nurse practitioners and nurse midwives in the state to modify procedures for license renewal to include the collection of specified information for each board's regular renewal cycle. The purpose of this requirement is to assist the state in tracking the availability of health care providers to determine which areas in the state suffer from inequitable access to specific types of health services and to anticipate future health care shortages which might adversely affect the citizens of the state. The licensing boards must collect information and report and update the information on an annual basis to the Department of Human Resources, which must provide this information to programs preparing primary care physicians, physician assistants and nurse practitioners upon request by the program and by the Board of Governors of the University of North Carolina. Information provided by the occupational licensing boards may be provided in such form as to omit the identity of the health care licensee.

OH **1996 Ohio Laws, H. 595** permits registered pharmacists to sell dialysis drugs and supplies directly to the patients for self-administration, according to a physician's orders. The act exempts them, when selling dialysis drugs and supplies for self administration, from certain prescription record-keeping requirements and requirements that registered pharmacists sell the drugs and control their pharmacies. In the case of an applicant who is a retail seller of peritoneal dialysis solutions in original packages, the applicant must maintain supervision and control over the possession, custody and retail sale of the peritoneal dialysis solutions.

OH **1996 Ohio Laws, S. 154** provides for issuance by the Board of Nursing of certificates of authority to practice nursing as a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner. The act defines the scope of practice and establishes certification and educational requirements for each nursing specialty and establishes requirements for collaboration with or supervision by a physician, podiatrist, or dentist. The act extends until January 1, 2010, the pilot programs for advanced practice nurses operated by the schools of nursing at Case Western Reserve University, Wright State University and the University of Cincinnati. The act also creates the Direct Entry Midwifery Study Council consisting of 11 members to study the regulation of direct entry midwives.

OH **1996 Ohio Laws, S. 246** authorizes an individual who is certified to conduct diabetes education to possess insulin if the person is professionally licensed, certified, or registered by the state and diabetes education is within the individual's scope of practice; authorizes possession of hypodermic needles for educational purposes; and repeals the prohibition against discarding hypodermics before rendering them unusable.

OK	**1996 Okla. Sess. Laws, Chap. 136 (SB 537)** provides that the Oklahoma Board of Nursing shall determine the duties that may be delegated to advanced unlicensed assistive persons and establishes a working committee to create a certification program for such persons.
OK	**1996 Okla. Sess. Laws, Chap. 157 (SB 1314)** requires competency certification for all individuals under contract with the state health care authority for personal care services.
OK	**1996 Okla. Sess. Laws, Chap. 186 (SB 587)** gives limited authority to nurse practitioners to prescribe from a formulary, provided the nurse practitioners have written agreements with supervising physicians.
OK	**1996 Okla. Sess. Laws, Chap. 261 (HB 2887)** cracks down on student loan defaulters by allowing the Oklahoma State Regents for Higher Education to notify any licensing board in Oklahoma (including the Department of Public Safety, which issues driver licenses) of student loan defaults and requires licensing boards to suspend the license until further notice from the State Regents. before suspension, licensees in default will have the opportunity for a hearing and the opportunity to enter into a satisfactory repayment agreement. The measure also allows the State Regents to establish programs for administrative garnishment and wage withholding to collect on defaulted student loans.
OK	**1996 Okla. Sess. Laws, Chap. 264 (SB 810)** transfers from the University Hospitals Authority to the University Hospitals Trust, upon closing of an agreement for the operation of the hospitals, $15 million to cover anticipated startup costs of the proposed joint venture with Columbia/HCA and any severance costs for former state employees that the trust may incur due to an agreement with a private entity.
OK	**1996 Okla. Sess. Laws, Chap. 321 (HB 2497)** concerns the proposed joint venture with Columbia/HCA to operate the University Hospitals and adjacent Presbyterian hospital. The measure requires any agreement to contain an independent statement as to the fairness of the contract to the state and assigns responsibility for overseeing the agreement to the University Hospitals authority. The act also creates a University Hospitals Trust Legislative Advisory Task Force.
OK	**1996 Okla. Sess. Laws, Chap. 326 (SB 811)** establishes certain mandates for any agreements that the University Hospitals Trust might enter into with a private entity for operation of the University Hospitals, including that all major decisions be approved by a majority of the state appointees to the governing entity.
OK	**1996 Okla. Sess. Laws, Chap. 336 (SB 1177)** directs the Department of Health to investigate the compliance history of a nursing home owner in all previous corporate forms, including nursing home operations in other states, when the owner is applying for a certificate of need license and expands the responsibility of the Department of Health for nurses aide certification and oversight of nurses aide training.
OK	**1996 Okla. Sess. Laws, Chap. 349 (HB 2648)** expands certification of home health aides to include continuing education requirements and provides for certification of home health care agency administrators.
OR	**1996 Or. Laws (1996 Spec. Sess.), Chap. 21(SB 1166)** repeals requirements for issuance by the Oregon State Board of Nursing of certificate of special competency to practice as a neonatal nurse practitioner.
PA	**1996 Pa. Laws, Act 113 (HB 1855)** adds to the State Board of Dentistry the power to require, as a condition of renewal of any license or certificate, the maintenance of current certification to administer cardiopulmonary resuscitation (CPR). The board may recognize the maintenance of certification in CPR or basic life support offered by a bona fide charitable organization.
PA	**1996 Pa. Laws, Act 141 (HB 2511)** enacts the Volunteer Health Services Act to increase the availability of primary health care services by establishing a procedure through which physicians

and other health care practitioners who are retired from active practice may provide professional services as a volunteer in approved clinics serving financially qualified persons and in approved clinics located in medically underserved areas or health professionals shortage areas.

RI **1996 R.I. Pub. Laws, Chap. 429 (SB 2789)** allows certified registered nurse practitioners to prescribe schedule II-V controlled substances.

SC **1996 S.C. Acts, Act 390 (H 3915)** authorizes and grants to the Board of Trustees of the Medical University of South Carolina (MUSC) the authority to enter into reasonable agreements to transfer the management and operations of the Medical University Hospital to one or more private operators, subject to certain conditions, including that a private operator must provide indigent care in the same manner as now provided by MUSC. In addition, MUSC must maintain the level of services currently offered to indigent patients at Charleston Memorial Hospital, unless the board decides otherwise. Any discontinuation or transfer of any inpatient clinical service offered at the Medical Center the law requires prior written consent of the Board of Trustees. Access for anyone or group to use the services of the Medical University Hospital and clinical services must not be limited, restricted, denied, or allowed in a discriminatory manner prohibited by law, nor must access be denied based on lack of participation or membership in a particular health plan or network. This act ensures MUSC retains access at all times to all records of all patients treated at the Medical University Hospital and all patients retain access at all times to their own records.

SD **1996 S.D. Sess. Laws, Chap. 7 (SB 51)** establishes a midlevel tuition reimbursement program for physician assistants and nurse practitioners.

SD **1996 S.D. Sess. Laws, Chap. 136 (SB 285)** makes an appropriation for family practice residency programs, requires an annual report of these programs and requires a report regarding the recruitment of family practice physicians.

SD **1996 S.D. Sess. Laws, Chap. 138 (SB 50)** revises certain provisions of the medical education scholarship program. Each academic year, the Board of Regents, upon recommendation of the medical school, shall select up to six students in each entering undergraduate class of the University of South Dakota School of Medicine to receive medical education scholarships. Any student selected to receive this medical education scholarship shall sign a contract agreeing to become a family physician, serve an area of the state which was determined by the Department of Health to be medically underserved, pay the amount of tuition waived plus interest if the student informs the Board of Regents in writing of the intention not to fulfill the obligations under the contract and pay three times the amount of tuition waived if the student completes undergraduate medical education but does not fulfill the terms of the contract plus attorney fees for collection of the amount owed. The amount owed by a student shall be reduced annually by a percentage calculated by dividing one by the number of years for which the student is contractually obligated.

SD **1996 S.D. Sess. Laws, Chap. 228 (H 1268)** provides for the formation of professional service corporations by licensed nurse practitioners or licensed nurse midwives and specifies requirements regarding professional liability insurance.

TN **1996 Tenn. Pub. Acts, Chap. 627 (H 1335)** adds registered nurses to the category of health care professionals who are eligible for reimbursement under insurance contracts, plans and policies issued or renewed on or after July 1, 1995.

TN **1996 Tenn. Pub. Acts, Chap. 651 (S 2091)** adds sections to the Tennessee Pharmacy Practice Act of 1996 defining the practice of pharmacy within the state and the goals of pharmacy practice to protect the health and safety of the residents. The act authorizes pharmacists to conduct and assist patients with tests approved for in-home use, but does not authorize pharmacists to order laboratory tests or prescription drugs except according to a medical order by the attending physician for each patient.

TN **1996 Tenn. Pub. Acts, Chap. 659 (S 2377)** requires the division of health-related boards to provide the board of pharmacy with the names of all nurse practitioners and physician assistants who are authorized to issue prescriptions and legend drugs and the names of their supervising physician. For each nurse practitioner, the board should also receive the list of drugs and the prescriptive services that may be issued by the nurse. It is understood that any prescription made by a nurse practitioner is under the control of the supervising physician. Any nurse practitioner or physician assistant who has been given authority to prescribe legend drugs must file a notice with the Primary Care Advisory Board giving his or her name, the supervising physician and a copy of the list describing the categories of legend drugs that may be prescribed. Both the nurse practitioner and physician assistant must maintain the protocol of their services, which will remain readily accessible to anyone upon request.

TN **1996 Tenn. Pub. Acts, Chap. 674 (S 2429)** adds birthing centers to the list of health facilities that require a license to operate and that the Department of Health is authorized to license. The act gives the board of the department the power to adopt rules and regulations pertaining to the operation and management of birthing centers and requires the centers to have an inspection once a year. The act authorizes the department to initiate proceedings seeking injunctive and any other forms of relief against people operating birthing centers. The act sets licensing fees for birthing centers based on the number of beds. Finally, the act requires birthing centers to adopt appropriate policies and procedures regarding the testing of patients and staff for HIV.

TN **1996 Tenn. Pub. Acts, Chap. 712 (S 2510)** authorizes the board of osteopathic examination to issue special training licenses to osteopathic medical interns, residents and fellows who have met all other qualifications except the completion of the necessary residency or training programs and the licensure examination.

TN **1996 Tenn. Pub. Acts, Chap. 835 (H 876)** requires any health care practitioner who knows, or has reasonable cause to suspect, that a patient's injuries are the result of domestic violence or abuse to make a report to the local police department or other local law enforcement agency within 10 business days following the patient's treatment date.

TN **1996 Tenn. Pub. Acts, Chap. 1042 (S 2511)** creates a board of osteopathic examination consisting of six state residents appointed by the governor, including a citizen who does not engage in a profession or business regulated by the board and five osteopathic physicians who are graduates of legally chartered osteopathic colleges and have been in practice for five years. The act encourages the governor to appoint at least one racial minority and one person over age 60.

TN **1996 Tenn. Pub. Acts, H. Jt. Res. 431** continues the special joint committee to study women's health issues for two years to further study and make recommendations on numerous other women's health issues. The resolution also notes that the special joint committee has voted to support the proposed statewide Center of Excellence of Women's Health to be based at the University of Tennessee Memphis-Medical. This proposed Center of Excellence would serve as a national model for women's health in research, prevention and service by providing statewide education efforts in rural and underserved areas and developing health professional training and curriculum in women's health. The University of Tennessee network of providers and agencies across the state would be an integral part of this effort.

UT **1996 Utah Laws, Chap. 345 (HB 302)** creates a scholarship and educational loan repayment and retention program, to be paid off with years of service, to encourage primary health care providers to practice in medically underserved urban areas. The act creates a committee and its responsibilities and provides for management of the program, including defaults. Program funding will be by line item appropriation, with $100,000 appropriated for FY 1996-97.

VT **1996 Vt. Acts, Act 171 (S 71)** defines and regulates the practice of naturopathic medicine. Naturopathic medicine is a system of health care that utilizes education, natural medicines and natural therapies to support and stimulate a patient's intrinsic self-healing processes to prevent, diagnose and treat human health conditions and injuries. Only a person who is licensed by the Office of Professional Regulation may practice naturopathic medicine or use a title indicating or implying that he or she is a naturopathic physician.

The act authorizes two studies: one will look at the organizational structure of the health-related boards attached to the Office of Professional Regulation; the other will focus on midwifery and home birth activities that may be performed by health care professionals other than licensed medical doctors.

Finally, the act removes the requirement that unprofessional conduct investigation reports be forwarded to the attorney general and authorizes the release of information regarding any licensee who is reported to have abused, neglected or exploited an elderly or disabled adult to the Office of Professional Regulation.

VA **1996 Va. Acts, Chap. 166 (HB 1279)** establishes mandatory certification of massage therapists under the aegis of the Board of Nursing.

VA **1996 Va. Acts, Chap. 183 (HB 98)** allows practitioners to authorize registered and licensed practical nurses to possess heparin and sterile normal saline to use for the maintenance of intravenous access lines. Presently, nurses may only be authorized to possess and administer epinephrine.

VA **1996 Va. Acts, Chap. 388 (HB 372)** allows a nurse who has equivalent credentials from a foreign country to participate in clinical practice while in an advanced professional nursing program, but only to the limits of the required curriculum. Currently, there are similar exemptions for physicians and dentists, but nurses must be licensed before participating in the clinical portions of educational programs.

VA **1996 Va. Acts, Chap. 406 (HB 696)** provides that physician assistants and qualified emergency medical services personnel may administer drugs upon the order of a practitioner. The act allows registered nurses or licensed practical nurses under the supervision of a registered nurse to administer vaccines to adults for immunization when a practitioner with prescriptive authority is not present.

VA **1996 Va. Acts, Chap. 748 (SB 384)** clarifies immunity from liability which is currently provided for health care providers while delivering services without charge. This provision modifies the provisions relating to hospitals, clinics and health professionals to allow a reasonable minimum fee to cover administrative costs for the delivery of medical or other health services as well as dental services and to affirm the immunity of clinics that so charge.

WA **1996 Wash. Laws, Chap. 22 (SB 6150)** gives the ability to certain health care professionals to form single professional service corporations or limited liability companies. The act clarifies that medical and osteopathic physicians may continue to form personal service corporations or limited liability companies. The applicability of the Uniform Disciplinary Act and other health care professional statutes is affirmed.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** amends the HMO act, adding sections pertaining to quality assurance, reimbursement for ambulance services, rural HMOs and other reforms. The act amends the definition of health care services to include chiropractic services and podiatric services. The definition of primary care physician is amended to allow a certified nurse-midwife to be chosen in lieu of a subscriber's primary care physician during the subscriber's pregnancy and for a period extending through the end of the month in which the 60-day period following termination of pregnancy.

WI **1996 Wis. Laws, Act 442 (AB 1034)** creates the Council on Health Care Fraud and Abuse, attached to the Department of Administration. The council consists of 15 members, including someone with expertise in the medical assistance program, as well as representatives of insurers, employee benefit plan administrators, HMOs, physicians, other health care providers and law enforcement. The council will develop strategies to combat health care fraud and abuse by consumers, providers and insurers, examine problems that relate to electronic claims for payment, survey efforts of other states to reduce fraud and abuse, conduct public hearings and engage in public information programs concerning health care fraud and abuse. The act requires the council to report annually to the governor and the legislature. The report must identify different types of fraud and abuse in health care, analyze related issues such as self-interested referrals, list successful prosecutions of health care fraud that have been conducted in the state courts, specify activities conducted by the council to combat the problem and recommend specific proposed changes to state statutes or administrative rules. The council terminates on December 30, 2000.

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RURAL HEALTH

AZ **1996 Ariz. Sess. Laws, Chap. 154 (SB 1016)** extends the board of medical student loans until July 1, 2001, and adds to its duties the responsibility to collect and maintain data on the retention of doctors who practice in rural and other medically underserved areas.

AZ **1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)** amends the definition of primary care disciplines to include family medicine, general internal medicine, general pediatrics and obstetrics and gynecology. This definition is amended for purposes of the mandate on the University of Arizona School of Medicine to reserve at least 60 percent of its available residency positions for medical school graduates entering programs defined as primary care disciplines of which at least 12 percent must be reserved for medical school graduates entering the family medicine program.

The act also amends the rural health professions program and requires the three universities under the jurisdiction of the Arizona Board of Regents to select 10 nurse practitioner students, 15 medical students and four pharmacy students each year to participate in the rural health professions program. The university must attempt to ensure that each individual participating student be able to fulfill the program requirements in a single rural practice setting. Pharmacy and medical students in the program will be placed in rural settings for a duration of at least one month during the summer months between academic years as part of the required curriculum during a clinical clerkship and in the final year of training. Nurse practitioner students in the program will be placed in rural settings in the state during the summer months between their first and second academic year.

DE **Vol. 70 Del. Laws, Chap. 516 (SB 418)** reauthorizes the Delaware Institute of Medical Education and Research (DIMER) by reconstituting it as an advisory board to the Delaware Health Care Commission. The act expands representation on the DIMER board, emphasizes DIMER's statewide responsibilities and expands its purpose to help the state meet its health care needs. The act requests that the board look at expanding of opportunities to training at a reasonable cost in the health and health-related professions when state residents commit to practice their professions in Delaware, offering incentives for qualified personnel in the health and health-related professions to practice in Delaware and continuing to develop a coordinated program of premedical, medical and graduate education among state public institutions of higher learning, Delaware hospitals and Jefferson Medical College. The board is encouraged to support graduate and post-graduate medical and health care training programs, including emphasis on those programs targeted to meet the state's health care needs and programs of education, training and research in the health fields, including the vital areas of public health education, community health planning and health care costs. The act gives the board the responsibility for developing a recruitment program for medical education in conjunction with local colleges and universities to encourage medical school applications from minorities and residents of rural counties and underserved areas of Delaware, in addition to other students interested in pursuing a medical education.

FL **1996 Fla. Laws, Chap. 509 (HB 2005)** clarifies that the Palm Beach County Health Care District's authority includes the ability to plan, set policy and fund from its revenue sources the establishment and implementation of cooperative agreements with other government authorities and public and

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private entities within and outside of Palm Beach County which promote the efficiencies of local and regional trauma agencies, rural health networks and cooperative health care delivery systems, provided that any agreements with entities outside of Palm Beach County ensure that the costs associated with trauma services are the responsibility of that entity. The district also has the authority to reorganize any of the hospitals it owns in accordance with state law.

MN **1996 Minn. Laws, Chap. 395 (SF 2849)** provides $14.4 million for higher education spending including $6.6 million to restructure the University of Minnesota academic health center, improve technology and update the curriculum. Ninety percent of the academic health center appropriation--about $5.9 million--is contingent upon making changes to the personnel policies in the center. The act requests that the school pursue changes in the tenure code for the academic health center without infringing on academic freedom. The remaining 10 percent of the $6.6 million for the academic health center is earmarked for the University of Minnesota-Duluth (UMD) medical school. The money hinges on the continued development of the medical school as a rural health center, which aims to produce more medical professionals to serve rural areas. Another $2 million in the act will be used for interactive communications technology to link academic health center facilities in Minneapolis, St. Paul and Duluth and other community-based sites. Most of the remaining money will be used to bolster technology at the state's higher education institutions.

NM **1996 N.M. Laws, Sen. Jt. Res. 31** resolves that the Department of Health study the feasibility of expanded emergency medical services in rural, medically underserved communities throughout the state as one major asset to be included in any managed care plans for the area. The department is requested to report its findings to the interim legislative health and human services committee at its October 1996 meeting.

TN **1996 Tenn. Pub. Acts, H. Jt. Res. 431** continues the special joint committee to study women's health issues for two years to further study and make recommendations on numerous other women's health issues. The resolution also notes that the special joint committee has voted to support the proposed statewide Center of Excellence of Women's Health to be based at the University of Tennessee Memphis-Medical. This proposed Center of Excellence would serve as a national model for women's health in research, prevention and service by providing statewide education efforts in rural and underserved areas and developing health professional training and curriculum in women's health. The University of Tennessee network of providers and agencies across the state would be an integral part of this effort.

WV **1996 W. Va. Acts, Chap. 151 (HB 4511)** provides that when a HMO enrollee receives covered emergency health care services from a noncontracting provider, the HMO is responsible for payment of the provider's normal charges for those health care services, exclusive of any applicable deductibles or copayments. In addition, the act expresses legislative intent that ambulance services in the state are performed by various volunteer emergency service squads, county operations and small businesses that may lack the sophistication and expertise required to negotiate a contract with an HMO for the provision of ambulance services and that the best interests of the state require the continued development and preservation of an emergency medical system to serve all the citizens of the state, including those who do not receive health care services through an HMO. The act directs the commissioner of insurance to promulgate legislative rules to regulate contracting for emergency medical services, including reimbursement for nonemergency transportation by non-participating providers and the appropriate use of 911 or community dispatching. The promulgated rules will be considered by the legislature in the 1997 regular session.

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SCHOOL HEALTH

CT **1996 Conn. Acts, P.A. 96-229 (HB 5794)** requires local and regional boards of education to provide annual posteral screenings for students in grades five through nine. Previously, such screenings were required only in the fifth and eighth grades.

DE **Vol. 70 Del. Laws, Sen. Jt. Res. 19** resolves that the Department of Public Instruction and the Department of Health and Social Services submit a plan analyzing existing capacity to educate the state's citizens about cancer and related chronic diseases and their risk factors. The plan should include ways to improve educational efforts; and an estimate of the costs to provide adequate public education, including start-up costs and annual operation and maintenance costs. In addition, the plan should examine existing coordination efforts between the two departments and between the departments and the voluntary and private health providers with an interest in cancer education and explain how the departments intend to coordinate future efforts, including school-based health centers, in developing expanded comprehensive health education. The proposal should also evaluate how existing school health curricula are being implemented at the local and district levels and make recommendations on a public awareness campaign about the risks of tobacco use targeted at youth and how to incorporate skill-building activities for healthier alternative behaviors in comprehensive school health education programs at all levels. The plan should also address how to educate the general population on the prevention of chronic diseases in general and cancer specifically. The plan must be submitted to the General Assembly on or before January 1, 1997.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** allows the Children's Medical Services network to contract with school districts participating in the certified school match program for the provision of school-based speech, occupational and physical therapy services for Medicaid-eligible children enrolled in the Children's Medical Services network.

FL **1996 Fla. Laws, Chap. 294 (HB 483)** requires each district school board to include in its approved school health services plan a procedure to provide training to the school personnel designated by the principal to assist students in the administration of prescribed medication. The training must be provided by a registered nurse, a licensed practical nurse, a physician, or a physician assistant. The training may be provided in collaboration with other school districts, through contract with an education consortium, or by any other arrangement consistent with the intent of the act. For all other invasive medical services, a registered nurse, a licensed practical nurse, a physician, or a physician assistant must determine if nonmedical school district personnel can perform such service. The act restricts school district personnel from referring students to or offering students at school facilities contraceptive services without the consent of a parent or legal guardian.

HI **1996 Hawaii Sess. Laws, Act 287 (HB 2800)** makes appropriations to the Department of Education, the Department of Human Services and the Department of Health, provided that the departments work together to develop working agreements regarding services provided to children through school-based health centers. These agencies are required to create an interdepartmental program for the development of pilot projects to demonstrate mental health, education and protective services to children and adolescents who are clients of more than one agency.

MI **1996 Mich. Pub. Acts, Act 287 (HB 5741)** provides that nothing in the school code shall be construed to authorize compulsory physical examination or compulsory medical treatment of pupils.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** authorizes the Department of Community Health to pursue reimbursement for eligible services provided in Michigan schools from the federal Medicaid program. The department and the department of management and budget are authorized to negotiate and enter into agreements, together with the Department of Education with local and intermediate school districts regarding the sharing of federal Medicaid services funds received for these services. (See "Medicaid" for a more detailed summary.)

MS **1996 Miss. Laws, Chap. 440 (SB 2573)** establishes a student vision screening program within the state Department of Education to make eye screening services available to public school students. The act also provides for the appointment of an advisory committee to review vision screening services offered under contract with the state Department of Education.

NH **1996 N.H. Laws, Chap. 277 (SB 599)** adds physician assistants and advanced registered nurse practitioners as individuals who may perform physical examinations of pupils. The act authorizes school nurses to possess and administer, with written parental authorization, certain drugs for disease prevention and emergency treatment, setting forth the duties of school nurses in the control and prevention of communicable disease.

NJ **1996 N.J. Laws, Chap. 42 (SB 3)** provides that each local school district that participates in the Special Education Medicaid Initiative shall receive a percentage of the federal revenue the district's participation yields for current year claims. The percentage share for local school districts shall be 15 percent of the first $53 million of federal reimbursements realized. After federal reimbursements are realized in excess of $53 million, local school districts shall receive a percentage of such revenue based on the level of participation they achieve.

NM **1996 N.M. Laws, Chap. 62 (HB 29)** delays the mandatory employment of school nurses until July 1, 1997. At that time, public schools will have to employ full-time, department-certified nurses per each 55 teachers employed by a school district or equivalent part-time, department-certified nurses for less than 55 teachers.

UT **1996 Utah Laws, Chap. 4 (HB 10)** requires local school boards to implement rules prescribed by the Department of Health for giving abnormal spinal curvature examinations to students. The rules must include exemptions for students whose parents or guardians feel such an examination violates personal beliefs.

UT **1996 Utah Laws, Chap. 229 (HB 135)** encourages collaboration between school districts, local health departments and private medical providers to determine needs and risks to students' health and develop and implement plans to minimize risks and meet needs. School districts are encouraged to provide one registered nurse for every 5,000 students, or, in districts with fewer than 5,000 students, at a level of service recommended by the Department of Health. The act provides for a School Nursing Services Incentive Program to encourage collaborative planning between school districts and local health departments. Incentive money is available by application and are distributed by formula.

VA **1996 Va. Acts, Chap. 864 (HB 1440)** requires the Department of Medical Assistance Services, in cooperation with the Department of Education, to examine the funding and components of the pilot school/community health centers. The Department may revise these programs. Any revisions must be designed to maximize access to health care for poor children and to improve the funding by making use of every possible, cost-effective means, Medicaid reimbursement or program. Any revisions also must be focused on prevention of large costs for acute or medical care and will include such concerns as: funding sources and means of distribution of the state match; benefits and drawbacks of allowing school divisions to provide services to disabled students as Medicaid providers in cooperation with their primary care physicians; the appropriate credentials of the providers of care in the school health centers; utilization of the Individualized Education Plan (IEP), when signed by a physician, as the plan of care; delivery of medically necessary services; and payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT); and the role of Medallion and Options programs in regard to the school health centers. Any funds necessary to support revisions to the school/community health center projects must be included in the budget estimates for the departments, as appropriate, for the next biennial budget.

SPECIAL HEALTH CARE NEEDS AND DISEASES

(SEE ALSO INSURANCE; MEDICAID AND NEWBORN SCREENING SECTIONS)

AL **1996 Ala. Acts, Act 704 (H 327)** makes an appropriation from the Education Trust Fund to the sickle cell education program for the fiscal year ending September 30, 1997.

AL **1996 Ala. Acts, Act 727 (H250)** creates the Alabama Sickle Cell Oversight and Regulatory Commission and provides for its power, duties and appointments.

CO **1996 Colo. Sess. Laws, Chap. 265 (SB 178)** authorizes a statewide pilot program that would allow people with disabilities to self-direct their attendant support. The law also includes the Department of Human Services, with the Department of Health Care Policy and Financing, in the residential child health care program and expands the residential child health care program to include the provision of services to developmentally disabled children who are neglected or dependent, who meet the out-of-home placement criteria set forth in the Colorado Children's Code, and who are placed through county departments of social services in licensed or certified out-of-home placement facilities in addition to residential child care facilities.

CT **1996 Conn. Acts, P.A. 96-185 (SB 68)** makes the Department of Mental Retardation (DMR), instead of the Education Department, the lead agency for the Birth-to-Three Program, a statewide early intervention system to provide services to all children from birth to three years old who are developmentally delayed or diagnosed with a condition highly correlated with developmental delay, such as Down's Syndrome or fetal alcohol syndrome. A sunset provision that would have terminated the program on June 30, 1996, is eliminated.

CT **1996 Conn. Acts, P.A. 96-229 (HB 5794)** requires local and regional boards of education to provide annual posteral screenings for students in grades five through nine. Previously, such screenings were required only in the fifth and eighth grades.

DE **Vol. 70 Del. Laws, Sen. Jt. Res. 19** resolves that the Department of Public Instruction and the Department of Health and Social Services submit a plan analyzing existing capacity to educate the state's citizens about cancer and related chronic diseases and their risk factors. The plan should include ways to improve educational efforts; and an estimate of the costs to provide adequate public education, including start-up costs and annual operation and maintenance costs. In addition, the plan should examine existing coordination efforts between the two departments and between the departments and the voluntary and private health providers with an interest in cancer education and explain how the departments intend to coordinate future efforts, including school-based health centers, in developing expanded comprehensive health education. The proposal should also evaluate how existing school health curricula are being implemented at the local and district levels and make recommendations on a public awareness campaign about the risks of tobacco use targeted at youth and how to incorporate skill-building activities for healthier alternative behaviors in comprehensive school health education programs at all levels. The plan should also address how to educate the general population on the prevention of chronic diseases in general and cancer specifically. The plan must be submitted to the General Assembly on or before January 1, 1997.

FL **1996 Fla. Laws, Chap. 148 (SB 308)** establishes an additional regional autism center at the University of Florida at Jacksonville to serve specified counties formerly served by the autism center at the College of Medicine at the University of Florida.

FL **1996 Fla. Laws, Chap. 199 (SB 886)** allows the Children's Medical Services network to contract with school districts participating in the certified school match program for the provision of school-based speech, occupational and physical therapy services for Medicaid-eligible children enrolled in the Children's Medical Services network.

FL **1996 Fla. Laws, Chap. 292 (HB 437)** requires the Department of Health and Rehabilitative Services to establish a sickle-cell program to the extent that resources are available. The act provides for education and screening as well as cooperation with and grants to, not-for-profit centers.

FL **1996 Fla. Laws, Chap. 294 (HB 483)** requires each district school board to include in its approved school health services plan a procedure to provide training to the school personnel designated by the principal to assist students in the administration of prescribed medication. The training must be provided by a registered nurse, a licensed practical nurse, a physician, or a physician assistant. The training may be provided in collaboration with other school districts, through contract with an education consortium, or by any other arrangement consistent with the intent of the act. For all other invasive medical services, a registered nurse, a licensed practical nurse, a physician, or a physician assistant must determine if nonmedical school district personnel can perform such service. The act restricts school district personnel from referring students to or offering students at school facilities contraceptive services without the consent of a parent or legal guardian.

FL **1996 Fla. Laws, Chap. 420 (HB 2717)** authorizes the Agency for Health Care Administration to apply managed care strategies to children's therapeutic services and requires that the agency coordinate with the Department of Juvenile Justice and the Alcohol, Drug Abuse and Mental Health Program Office and Children and Families Program Office of the Department of Health and Rehabilitative Services to develop the appropriate clinical protocols and identify the services to be included for preauthorization and utilization management.

FL **1996 Fla. Laws, Sen. Res. 1824** recognizes April as "Early Intervention Awareness Month" and urges all residents to support the state's early intervention programs and services that promote healthy environments and optimal development for children.

GU **1996 Guam Laws, P.L. 23-76** funds the Catastrophic Illness Assistance Program within the FY 96 budget of the Department of Public Health, increases the benefit cap from $100,000 to $175,000 and requires the adoption of rules and regulations in accordance with the Administrative Adjudication Law to administer the program.

HI **1996 Hawaii Sess. Laws, Act 125 (HB 3498)** assigns the responsibility for the coordination of mental health services for children and adolescents required by the *Felix vs. Cayetano* settlements agreement and any future legal actions to the Department of Health.

HI **1996 Hawaii Sess. Laws, Act 287 (HB 2800)** makes appropriations to the Department of Education, the Department of Human Services and the Department of Health, provided that the departments work together to develop working agreements regarding services provided to children through school-based health centers. These agencies are required to create an interdepartmental program for the development of pilot projects to demonstrate mental health, education and protective services to children and adolescents who are clients of more than one agency.

IN **1996 Ind. Acts, P.L. 112 (HB 1355)** creates the family subsidy program account to provide flexible funding for families caring for disabled individuals at home, and provides that money appropriated to the family subsidy program is transferred to the family subsidy program account.

IN **1996 Ind. Acts, P.L. 246 (HB 1354)** requires the Office of Medicaid Policy and Planning to seek federal approval to allow Indiana to increase by at least 175, before July 1, 1996, the number of waiver slots for individuals using an intermediate care facility for the mentally retarded under a home- and community-based waiver. The act also requires the Office of the Secretary of Family and Social Services to prepare a report concerning individuals with developmental disabilities.

IA **1996 Iowa Acts, Chap. 1084 (SF 2307)** relates to the Comprehensive Family Support Program for individuals with a disability and their families and provides for coordination of programs available to individuals with disabilities with other programs administered by the Department of Human Services. The act requires statewide implementation of the support program in a manner that enables individual choice of services and other provisions to individualize the manner in which the program is implemented. The act also requires that the application process be coordinated with the eligibility processes used by other programs, requires services and support to be provided in a timely manner with provision for emergency services and requires the department to assist eligible families in locating services and in identifying the components of service plans. The act includes provisions for a children-at-home component of the program. Under this component, the department assists a family member of an eligible family in identifying services and support needed. The act directs the department to develop a contract for direct payment utilizing vouchers for the services and other support provided to the family.

IA **1996 Iowa Acts, Chap. 1183 (HF 2427)** institutes a single entry point process for services relating to mental health, mental retardation, developmental disabilities and other services that are paid for in whole or in part by counties or the state. The act also amends county participation in funding for services to people with disabilities provisions to specify that the state shall pay for 100 percent of the nonfederal share of the services paid for under any prepaid mental health services plan for medical assistance implemented by the department as authorized by law.

KY **1996 Ky. Acts, Chap. 221 (HB 159)** authorizes the Council on Higher Education in Kentucky to operate a state autism training center and to contract with a public institution of higher education to carry out the program, which will offer education and training for professional personnel and family members or guardians.

KY **1996 Ky. Acts, Chap. 336 (HB 611)** requires that a person with a disability or a member of that person's family be included in the membership of each advisory board, committee, or commission, task force, or ad hoc committee, created specifically to develop or oversee policies or programs related to people living with a disability, of any executive cabinet or local community-based agency governing board that receives funds from any executive cabinet.

LA **1996 La. Acts, P.A. 27 (HB 84)** allows a person who maintains a household that includes one or more dependents who are physically or mentally incapable of caring for themselves to take as a credit against the state income tax the full amount of a tax credit equal to the applicable percentage of employment-related expenses allowable under the Internal Revenue Code. The amount of the unused credit may be carried forward to the next tax year.

LA **1996 La. Acts, H. Concur. Res. 42** requests the secretary of the Department of Health and Hospitals (DHH), in budget recommendations and DHH budget actions, to refrain from cutting any funding designated for people with mental retardation and developmental disabilities (MR/DD) and to refrain from cutting waiver slots provided for MR/DD-eligible recipients, but to seek to increase the services provided under such waiver provisions.

ME **1996 Maine Laws, Chap. 697 (LD 1764)** requires that any money identified as savings due to the closure of a state mental health facility or a diminution of services at any such facility and any money from administrative savings at the Department of Mental Health, Mental Retardation and Substance Abuse Services be used to provide those services in other appropriate settings and programs. The act defines these savings as net general fund savings generated through legislative or departmental actions less any cost or liability from implementing those actions.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** authorizes the Department of Community Health to pursue reimbursement for eligible services provided in Michigan schools from the federal Medicaid program. The department and the department of management and budget are authorized to negotiate and enter into agreements, together with the Department of Education with local and intermediate school districts regarding the sharing of federal Medicaid services funds received for these services. (See "Medicaid" for a more detailed summary.)

MN **1996 Minn. Laws, Chap. 451 (HF 1584)** clarifies that a medical assistance recipient may receive an initial assessment and up to two reassessments per year done to determine a recipient's need for personal care services. In the case of children with disabilities or mental illness, after a child is determines to be eligible for medical assistance, the commissioner must review the child's disability and level of care no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. (See "Medicaid" for more information.)

MS **1996 Miss. Laws, Chap. 476 (HB 87)** reestablishes the Children's Advisory Council to pilot the development of a coordinated system for services and care for children who are emotionally disturbed or mentally ill. The act revises the functions and the scope of the coordinated interagency system of children services pilot program and the composition and responsibilities of the council and the local coordinating care entity. The act provides that after the first year of the program, the Children's Advisory Council will add additional coordinating care entities so that all children in the state served by this act will be covered by the third year. The act provides for the contribution of funds into a pool of funds by participating agencies, including the Department of Human Services, the Department of Mental Health and the Department of Education. By the first quarter of each fiscal year, each of these agencies must pay into the special fund out of its annual appropriation, a sum to be determined by the governing board of each agency or other duly authorized state level oversight authority. The act provides that in lieu of contributing funds, the Department of Health must contribute to the pilot in-kind health/medical services.

MS **1996 Miss. Laws, Chap. 505 (S 2031)** establishes a system of treatment for people with spinal cord or traumatic injuries, to be implemented by the state Department of Rehabilitation Services. The act creates a spinal cord and head injury trust fund to provide the cost of treatment and rehabilitation, funded by a $4 assessment for moving traffic violations and a $25 assessment for violations of the implied consent law.

NH **1996 N.H. Laws, Chap. 193 (SB 590)** establishes a committee to study the feasibility of requiring insurers to cover early intervention services.

NJ **1996 N.J. Laws, Chap. 42 (SB 3)** provides that each local school district that participates in the Special Education Medicaid Initiative shall receive a percentage of the federal revenue the district's participation yields for current year claims. The percentage share for local school districts shall be 15 percent of the first $53 million of federal reimbursements realized. After federal reimbursements are realized in excess of $53 million, local school districts shall receive a percentage of such revenue based on the level of participation they achieve.

NM **1996 N.M. Laws, Sen. Jt. Mem. 48** requests the Department of Health to conduct a study of professional licensure for personnel in community programs that serve young children with developmental disabilities. The department must report its findings to the legislative health and human services committee no later than October 1, 1996.

SC **1996 S.C. Acts, Act 458 (H 4600, Sec. 53)** deletes the provision requiring families of infants and toddlers with disabilities to apply for a financial or medical assistance program as a condition of receiving early intervention services.

TN **1996 Tenn. Pub. Acts, Chap. 1025 (S 2134)** requires the commissioner of health to establish and maintain a central registry of those who sustain traumatic brain injury. The purpose of the registry is to collect information to facilitate the development of injury prevention, treatment and rehabilitation programs and to give people with traumatic brain injury information on public or private agencies that provide rehabilitation services so that injured persons may obtain needed services to alleviate injuries and avoid related secondary problems. The act gives the commissioner the power to collect and analyze injury incidence information and conduct special studies on the causes and consequences of traumatic brain injury.

UT **1996 Utah Laws, Chap. 4 (HB 10)** requires local school boards to implement rules prescribed by the Department of Health for giving abnormal spinal curvature examinations to students. The rules must include exemptions for students whose parents or guardians feel such an examination violates personal beliefs.

UT **1996 Utah Laws, Chap. 332 (SB 225)** requires family support services and associated case management services offered by the Division of Services for People with Disabilities be provided through vouchers or direct financial assistance. A voucher describes the services and supports that may be received and lists approved providers that may be used by a person with a disability or his parent or guardian to purchase services and supports. The voucher also includes a maximum dollar value, states the period of time within which the voucher must be used and is redeemable by an approved provider for payment by the division up to the dollar value of the voucher. The division must conduct an evaluation of the effects of providing vouchers and direct financial assistance under this act and report the results to the Human Services Interim Committee before December 31, 1998. To implement this act with regard to Medicaid funds, the Division of Health Care Financing within the Department of Health, in cooperation with the Division of Services for People with Disabilities is directed to submit an amendment to the state's Medicaid home- and community-based services waiver.

VA **1996 Va. Acts, Chap. 864 (HB 1440)** requires the Department of Medical Assistance Services, in cooperation with the Department of Education, to examine the funding and components of the pilot school/community health centers. The Department may revise these programs. Any revisions must be designed to maximize access to health care for poor children and to improve the funding by making use of every possible, cost-effective means, Medicaid reimbursement or program. Any revisions also must be focused on prevention of large costs for acute or medical care and will include such concerns as: funding sources and means of distribution of the state match; benefits and drawbacks of allowing school divisions to provide services to disabled students as Medicaid providers in cooperation with their primary care physicians; the appropriate credentials of the providers of care in the school health centers; utilization of the Individualized Education Plan (IEP), when signed by a physician, as the plan of care; delivery of medically necessary services; and payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT); and the role of Medallion and Options programs in regard to the school health centers. Any funds necessary to support revisions to the school/community health center projects must be included in the budget estimates for the departments, as appropriate, for the next biennial budget.

SUBSTANCE ABUSE (MATERNAL AND INFANTS)

AZ **1996 Ariz. Sess. Laws, Chap. 52 (HB 2264)** establishes the 17-member Implementation Oversight Committee on Perinatal Substance Abuse to advise the Department of Health Services (DHS) concerning the implementation of the recommendations of the Advisory Council on Perinatal Substance Abuse (1995 interim committee). The act specifies the composition of the committee and requires it to meet monthly, staffed by DHS. The committee will be repealed January 1, 1998.

IL **1996 Ill. Laws, P.A. 89-507 (HB 2632)** directs that the Departments of Alcoholism and Substance Abuse; Mental Health and Developmental Disabilities; and Rehabilitative Services are to become the Department of Human Services (DHS) on July 1, 1997. DHS will have responsibility for these health issues: infant mortality reduction; diabetes prevention; addicted pregnant women; and hemophilia treatment.

IL **1996 Ill. Laws, P.A. 89-517 (HB 3613)** allows the Department of Public Aid, in cooperation with the Departments of Alcoholism and Substance Abuse and Public Health, through a public awareness campaign, to provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

IA **1996 Iowa Acts, Chap. 1092 (SF 2410)** modifies a provision in law before the 1995 legislative session that prohibits the use of a positive medically relevant test in the criminal prosecution of a parent for acts and omissions resulting in intrauterine exposure of the child to an illegal drug. The modification limits the prosecution prohibition to tests obtained before the birth of the child. The act also provides that if a child is removed from the child's home under a court order due to the presence of an illegal drug in the child's body, the court is to allow reasonable or supervised visitation with the child's parent unless the court determines the visitation would cause an imminent risk to the child's life or health. The act directs the director of public health to utilize the Commission on Substance Abuse to study the effects of fetal alcohol syndrome on children and the issues associated with removal of a child based on the parent's substance abuse. The study process is to utilize statewide hearings and consultation with various public officials. The study findings are to be submitted to the Legislative Council and to the General Assembly.

MI **1996 Mich. Pub. Acts, Act 581 (HB 6140)** adds to reporting requirements related to child abuse and neglect that a person who is required to report suspected child abuse or neglect and who knows, or from the child's symptoms has reasonable cause to suspect, that a newborn infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in his or her body must report to the Family Independence Agency in the same manner as other reporting requirements. A report is not required if the person knows that the substance or the child's symptoms are the result of medical treatment administered to the newborn infant or his or her mother.

NH **1996 N.H. Laws, Chap. 252 (HB 1576)** allows for methadone to be administered, prescribed and dispensed to pregnant and postpartum heroin addicts and administered as part of an alcohol and drug abuse treatment program, which may include extended detoxification and which is approved by the commissioner of health and human services.

WI **1996 Wis. Laws, Act 386 (SB 94)** removes foster care or treatment foster care workers from the list of people who are allowed to refer an infant to a physician for testing of the infant's bodily fluids for controlled substances due to the mother's use of controlled substances while she was pregnant with the infant. The act removes the requirement that the parent or guardian consent to such a test and adds the stipulation that, in order to test the infant, a physician must determine that the health of the infant may be adversely affected by the controlled substances. Finally, the act eliminates the termination of the testing program.

TELEMEDICINE

AZ **1996 Ariz. Sess. Laws, Chap. 36 (HB 2224)** creates a new chapter regulating the practice of health care delivery through telemedicine and requires a provider to obtain verbal or written informed consent from a patient before delivery health care through telemedicine, with exceptions. The act also requires confidentiality protections for patients.

AZ **1996 Ariz. Sess. Laws, Chap. 342 (H 2440)** establishes a technology and telecommunications fund to fund the enhancement and extension of the Arizona telecommunications systems, including any transmission of voice, data, video, or graphic images. The act establishes a government information technology agency to maintain a statewide information technology plan. The act also establishes an information technology authorization committee to review statewide information technology standards and the plan and approve or disapprove projects that exceed $1 million.

CA **1996 Cal. Stats., Chap. 864 (SB 1665)** enacts the Telemedicine Development Act of 1996, setting standards for the use of telemedicine by health care practitioners and insurers. The act prohibits health insurers from requiring face-to-face contact between a health care provider and patient for services appropriately provided through telemedicine, subject to the terms of the contract.

CA **1996 Cal. Stats., Chap. 902 (SB 2098)** authorizes the Medical Board of California to develop a proposed registration program that would permit physicians, surgeons and podiatrists located outside the state to practice medicine across state lines and requires them to meet the legal requirements of the state.

CT **1996 Conn. Acts, P.A. 96-148 (SB 225)** requires physicians from other states performing diagnostic or treatment services for state residents through electronic communications or interstate commerce to be licensed in Connecticut. Treatment services include primary diagnosis of pathology specimens, slides, or images. The act also requires licensing of out-of-state physicians who provide official written reports of their diagnostic evaluations based on electronically transmitted radiographic images to in-state physicians or patients. A nonresident physician does not need a state license if he/she consults on an irregular basis with a Connecticut-licensed physician or consults with a medical school in Connecticut for educational or medical training purposes.

GA **1996 Ga. Laws, p. 1039 (S 46)** requires the Board of Regents of the University System of Georgia to prescribe criteria, policies and standards deemed necessary for the effective implementation of programs within the university system financed wholly or partially from appropriations from the Lottery for Education Account and provide professors and instructors the necessary training in the use and application of computers and advanced electronic instructional technology to implement interactive learning environments in the classroom and to access the statewide distance learning network.

IN **1996 Ind. Acts, P.L. 180 (HB 1294)** amends the definition of the "practice of medicine or osteopathic medicine" to include providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services: are transmitted through electronic communications; and

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are on a regular, routine and nonepisodic basis or pursuant to an oral or written agreement to regularly provide medical services.

NM **1996 N.M. Laws, H. Jt. Mem. 21** requests the state corporation commission and the appropriate legislative committee to cooperate in a study of telecommunications laws and regulations as they affect programs for distance learning, telemedicine and access to information and public services.

WV **1996 W. Va. Acts, Chap. 119 (SB 591)** requires establishment of a plan and funding recommendations for development and implementation of a multifaceted instructional technology strategy that includes the expansion of distance learning and technology networks throughout the higher education systems to enhance teaching and learning.

WOMEN'S HEALTH

AK **1996 Alaska Sess. Laws, Chap. 74 (SB 253)** requires certain insurers to provide coverage for the costs of prostate cancer and cervical cancer screening. The act specifies the minimum coverage required to be provided and that the required coverage does not apply to a supplemental insurance contract covering a specified disease or offering limited benefits.

CA **1996 Cal. Stats., Chap. 50 (SJR 52)** asks Congress and the president to enact legislation enabling postal stamp patrons to voluntarily donate one cent per stamp for supplemental breast cancer research.

CA **1996 Cal. Stats., Chap. 197 (AB 3483)** establishes a state-only family planning program under Medi-Cal, for a period of three years to provide family planning services to all of those with family incomes at or below 100 percent of the federal poverty level, who have no other health care coverage, except as described and are not otherwise eligible for Medi-Cal services without a share of cost.

CA **1996 Cal. Stats., Chap. 790 (AB 2125)** requires the Department of Health Services, in consultation with the Department of Social Services and the appropriate federal agency or department, to establish and implement appropriate education, preventative and outreach activities focusing on new immigrant populations that traditionally practice female genital mutilation. The act provides that a person who commits a felony violation by an act of female genital mutilation, as defined, shall be punished by an additional term of imprisonment in the state prison for one year, in addition and consecutive to any other punishment prescribed by law.

CA **1996 Cal. Stats., Chap. 1100 (AB 1291)** directs the Department of Health Services to establish two separate levels of registration fees for mammographic x-ray equipment, the lower of which is for registration of equipment already accredited by an independent accreditation agency, if recognized under the federal Mammography Quality Standards Act.

CT **1996 Conn. Acts, P.A. 96-177 (SB 330)** prohibits individual and group health insurance plans from refusing to cover an applicant who once suffered from breast cancer if she remains breast cancer-free for at least five years before applying for coverage. The act allows insurers to require the applicant to submit to a physical examination at the time of application. The act exempts follow-up breast cancer examinations from the scope of a health plan's preexisting condition exclusion.

CT **1996 Conn. Acts, P.A. 96-238 (SB 72)** establishes, within existing appropriations, a breast and cervical cancer early detection and treatment referral program within the Department of Public Health (DPH). The act requires DPH to provide mammography and pap tests for women ages 40 to 64 whose incomes are at or below 200 percent of the federal poverty level and who do not have health insurance that covers mammograms or pap tests for cancer screening. The act provides for one mammogram every two years for those under age 50, one mammogram every year for those over age 50 and one pap test for cervical cancer per year. DPH must report annually to the Public Health Committee.

DE **Vol. 70 Del. Laws, Chap. 472 (SB 405)** establishes a Breast Cancer Education and Early Detection Fund. An individual who claims an overpayment of taxes on an income tax return may designate that $1 or more be deducted from the refund and paid to the fund. An individual who has an income tax liability may, in addition to the obligation, include a donation of $1 or more to be paid to the fund. In both cases, the Division of Revenue will forward the designated amounts to Women and Wellness Inc., which must deposit them to the credit of the Delaware Chapter of the National Breast Cancer Coalition to be used for breast cancer education and early detection. From time to time as determined by the Delaware State Clearinghouse Committee, Women and Wellness must submit a report to the committee detailing revenues, expenditures and program measures for the fiscal period in question.

DE **Vol. 70 Del. Laws, H. Res. 86** encourages and requests the Division of Public Health of the Department of Health and Social Services to provide leadership in the promotion of public awareness and knowledge about the diagnosis, prevention and treatment of osteoporosis.

FL **1996 Fla. Laws, Chap. 223 (SB 910)** prohibits certain misrepresentations by HMOs on the availability of providers and specifies requirements for HMOs in providing emergency services and care. The act specifies an emergency medical condition with respect to a pregnant woman to mean there is inadequate time to effect safe transfer to another hospital before delivery, a transfer may pose a threat to the health and safety of the patient or fetus, or there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

FL **1996 Fla. Laws, Chap. 282 (HB 397)** establishes the osteoporosis prevention and education program within the Department of Health and Rehabilitative Services to be administered by the State Health Office, in consultation with the Department of Elderly Affairs. The act requires health plans to cover osteoporosis screening, diagnosis, treatment and management. The act amends the list of exemptions to include certain group health insurance policies that are issued or delivered outside the state.

FL **1996 Fla. Laws, H. Res. 9241** designates October 1996 as Breast Cancer Awareness Month.

KY **1996 Ky. Acts, Chap. 114 (HB 504)** requires insurers issuing individual or group or blanket health insurance policies in Kentucky that provide coverage for treatment of breast cancer by chemotherapy to also provide coverage for treatment of breast cancer by high-dose chemotherapy with autologus bone marrow transplantation or stem cell transplantation.

LA **1996 La. Acts, H. Concur. Res. 52** urges the Congress and the president of the United States to utilize American influence in international relations to end female genital mutilation in those countries where these procedures are presently practiced upon unwilling individuals. The act requests that the United States grant political asylum to individuals who flee their homelands to escape female genital mutilation.

ME **1996 Maine Laws, Chap. 617 (LD 1385)** requires all health plans to cover pap tests recommended by a physician, with a few exceptions for limited coverage plans.

MD **1996 Md. Laws, Chap. 365 (SB 59)** requires each hospital to offer mammography educational materials to each female patient when medically appropriate for the patient. The Department of Health and Mental Hygiene, in collaboration with specified entities, must select and approve or develop and print and update as necessary, the materials.

MD **1996 Md. Laws, Chaps. 375 and 376 (SB 181/HB 119)** require insurance plans to provide coverage for reconstructive breast surgery resulting from a mastectomy. The coverage must include all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry when reconstructive breast surgery is performed on the diseased breast.

MI **1996 Mich. Pub. Acts, Act 352 (SB 847)** makes appropriations for the Department of Community Health and specifies certain requirements for use of certain funds, including the following: from the state funds appropriated for the center for health promotion, the department must allocate funds to promote awareness, education and early detection of breast, cervical and prostate cancer and provide for other health promotion medical activities.

NY **1996 N.Y. Laws, Chap. 279 (S 7884)** creates a Health Research Science Board in the Department of Health (DOH) and establishes the Breast Cancer Research and Education Fund with personal and corporate income tax checkoffs dedicated to the fund. The act adds language to the corporate franchise tax and personal income tax law to permit a taxpayer or individual to contribute a financial gift to the Breast Cancer Research and Education Fund by checking the appropriate space provided on the tax return. The act declares that a donation will not reduce the amount of tax owed and that all revenues collected according to these provisions must be credited to the Breast Cancer Research and Education Fund and used only for those purposes.

OK **1996 Okla. Sess. Laws, Chap. 102 (HB 2261)** requires all health insurance providers, except certain limited benefit plans, to provide coverage for bone-density testing for people whose medical histories indicate a high risk of osteoporosis, when the test is requested by a primary care or referral physician.

OK **1996 Okla. Sess. Laws, Chap. 313 (HB 2063)** authorizes several new specialized license plates, including one regarding the fight against breast cancer.

RI **1996 R.I. Pub. Laws, Chap. 66 (HB 8842)** requires all health plans that cover physician services in a physician's office and all policies that provide major medical or similar comprehensive-type coverage to include coverage for prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the patient after a mastectomy. Coverage for prosthetic devices and reconstructive surgery are subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. Nothing in the act requires an individual or group policy to cover the surgical procedure known as mastectomy or to prevent the application of deductible or copayment provisions contained in the policy or plan, nor does anything in the act require that coverage under an individual or group policy be extended to any other procedures. Also, nothing in the act authorizes an insured or plan member to receive the coverage required by this act if that coverage is furnished by a non-participating provider, unless the insured or plan member is referred to that provider by a participating physician, nurse practitioner, or certified nurse midwife providing care.

TN **1996 Tenn. Pub. Acts, Chap. 835 (H 876)** requires any health care practitioner who knows, or has reasonable cause to suspect, that a patient's injuries are the result of domestic violence or abuse to make a report to the local police department or other local law enforcement agency within 10 business days following the patient's treatment date.

TN **1996 Tenn. Pub. Acts, Chap. 969 (H 2484)** allows all health plans that provide coverage for accident and health services and are delivered, issued for delivery, amended or renewed on or after July 1, 1996, to also provide coverage to a qualified individual for scientifically proven bone mass measurement (bone density testing) for the diagnosis and treatment of osteoporosis. The act does not mandate coverage.

TN **1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)** requires the TennCare Bureau to file a report at least annually setting forth data and statistics relative to health care provided to women. The act directs the TennCare Bureau and the Tennessee Department of Health to develop data measures to assess the effectiveness of presumptive eligibility, the distribution of providers for each managed care organization for TennCare enrollees within each health region and the incidences of early prenatal care for TennCare recipients. The managed care organizations are required to report regularly to the TennCare Bureau using the data measures developed.

TN **1996 Tenn. Pub. Acts, H. Jt. Res. 431** continues the special joint committee to study women's health issues for two years to further study and make recommendations on numerous other women's health issues, including the high rate of suicide for young women and other mental health needs, HIV/AIDS and prevention of sexually transmitted diseases, addictive disorders, cardiovascular disease and osteoporosis. The resolution notes that the committee has devised more specific recommendations relative to other women's health issues, including prenatal care, hospital discharge of mothers and newborns, TennCare coverage of high dose chemotherapy for breast cancer, the proposed Center of Excellence for Women's Health, osteoporosis research in state educational facilities and domestic violence.

The resolution also notes that the special joint committee has voted to support the proposed statewide Center of Excellence of Women's Health to be based at the University of Tennessee Memphis-Medical. This proposed Center of Excellence would serve as a national model for women's health in research, prevention and service by providing statewide education efforts in rural and underserved areas and developing health professional training and curriculum in women's health. The University of Tennessee network of providers and agencies across the state would be an integral part of this effort.

VA **1996 Va. Acts, Chap. 611 (SB 432)** requires health insurers and HMOs to provide coverage for annual pap smears.

WV **1996 W. Va. Acts, Chap. 135 (HB 4198)** creates the Osteoporosis Prevention Education Act and requires the Bureau of Public Health to promote and maintain the program, which is to include strategies for educating the public and health professionals. The act also establishes the Interagency Council on Osteoporosis to coordinate osteoporosis programs conducted by the Bureau of Public Health.

STATE-BY-STATE SUMMARY

State	Topic	Bill Number
Alabama		
	Access and Reform	1996 Ala. Acts, H. Jt. Res. 69
	Emergency Medical Services	1996 Ala. Acts, Sen. Jt. Res. 101
	Financing	1996 Ala. Acts, Act 704 (H 327)
	Injury Prevention	1996 Ala. Acts, Sen. Jt. Res. 101
	Access to Providers	1996 Ala. Acts, Act 671 (H 625)
	Insurance--Other Consumer Protections	1996 Ala. Acts, Act 651 (H395)
	Insurance--Other Consumer Protections	1996 Ala. Acts, Sen. Jt. Res. 56
	Medicaid	1996 Ala. Acts, H. Jt. Res. 69
	Minority Health	1996 Ala. Acts, Act 704 (H 327)
	Minority Health	1996 Ala. Acts, Act 727 (H250)
	Providers	1996 Ala. Acts, Act 671 (H 625)
	Special Health Care Needs and Diseases	1996 Ala. Acts, Act 704 (H 327)
	Special Health Care Needs and Diseases	1966 Ala Acts, Act 727 (H 250)
Alaska		
	Insurance--General	1996 Alaska Sess. Laws, Chap. 16 (HB 226)
	Insurance--Individual and Small Group	1996 Alaska Sess. Laws, Chap. 15 (SB 178)
	Insurance--Mandated Coverage	1996 Alaska Sess. Laws, Chap. 74 (SB 253)
	Insurance--Maternity Issues	1996 Alaska Sess. Laws, Chap. 49 (SB 193)
	Medicaid	1996 Alaska Sess. Laws, Chap. 83 (HB 393)
	Providers	1996 Alaska Sess. Laws, Chap. 5 (SB 123)
	Providers	1996 Alaska Sess. Laws, Chap. 91 (HB 480)
	Women's Health	1996 Alaska Sess. Laws, Chap. 74 (SB 253)
Arizona		
	Access and Reform	Prop. 203 (ballot initiative), 1996 General Election
	Access and Reform	1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)
	Coordination	1996 Ariz. Sess. Laws, Chap. 247 (HB 2277)
	Emergency Medical Services	1996 Ariz. Sess. Laws, Chap. 132 (SB 1286)
	Financing	Prop. 203 (ballot initiative), 1996 General Election
	Financing	1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)
	Immunization	1996 Ariz. Sess. Laws, Chap. 228 (HB 2134)
	Insurance--Other Consumer Protections	1996 Ariz. Sess. Laws, Chap. 132 (SB 1286)
	Insurance--State Sponsored Insurance	1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)
	Medicaid	Prop. 203 (ballot initiative), 1996 General Election
	Medicaid	1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)
	Medicaid	1996 Ariz. Sess. Laws, Chap. 288 (SB 1283)

Medicaid	1996 Ariz. Sess. Laws, Chap. 368 (HB 2508)
Nutrition	Prop. 203 (ballot initiative), 1996 General Election
Prenatal Care and Infant Mortality	Prop. 203 (ballot initiative), 1996 General Election
Prenatal Care and Infant Mortality	1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)
Prenatal Care and Infant Mortality	1996 Ariz. Sess. Laws, Chap. 240 (HB 2358)
Prevention and Primary Care	Prop. 203 (ballot initiative), 1996 General Election
Prevention and Primary Care	1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)
Prevention and Primary Care	1996 Ariz. Sess. Laws, Chap. 247 (HB 2277)
Prevention and Primary Care	1996 Ariz. Sess. Laws, Chap. 288 (SB 1283)
Providers	Prop. 203 (ballot initiative), 1996 General Election
Providers	1996 Ariz. Sess. Laws, Chap. 50 (HB 2342)
Providers	1996 Ariz. Sess. Laws, Chap. 154 (SB 1016)
Providers	1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)
Providers	1996 Ariz. Sess. Laws, Chap. 240 (HB 2358)
Rural Health	1996 Ariz. Sess. Laws, Chap. 154 (SB 1016)
Rural Health	1996 Ariz. Sess. Laws, Chap. 237 (HB 2301)
Substance Abuse (Women and Infants)	1996 Ariz. Sess. Laws, Chap. 52 (HB 2264)
Telemedicine	1996 Ariz. Sess. Laws, Chap. 36 (HB 2224)
Telemedicine	1996 Ariz. Sess. Laws, Chap. 342 (H 2440)

California

Access and Reform	1996 Cal. Stats., Chap. 954 (SB 38)
Access and Reform	1996 Cal. Stats., Chap. 199 (AB 3487)
Access and Reform	1996 Cal. Stats., Chap. 864 (SB 1665)
Access and Reform	1996 Cal. Stats., Chap. 902 (SB 2098)
Access and Reform	1996 Cal. Stats., Chap. 1012 (AB 2577)
Coordination	1996 Cal. Stats., Chap. 199 (AB 3487)
Emergency Medical Services	1996 Cal. Stats., Chap. 197 (AB 3483)
Emergency Medical Services	1996 Cal. Stats., Chap. 199 (AB 3487)
Emergency Medical Services	1996 Cal. Stats., Chap. 1012 (AB 2577)
Financing	1996 Cal. Stats., Chap. 50 (SRJ 52)
Financing	1996 Cal. Stats., Chap. 74 (AB 2804)
Financing	1996 Cal. Stats., Chap. 198 (AB 3484)
Financing	1996 Cal. Stats., Chap. 199 (AB 3487)
Financing	1996 Cal. Stats., Chap. 529 (SB 1636)
Financing	1996 Cal. Stats., Chap. 1099 (AB 1184)
Immunization	1996 Cal. Stats., Chap. 556 (SB 686)
Insurance--Access to Providers	1996 Cal. Stats., Chap. 527 (SB 1596)
Insurance--Access to Providers	1996 Cal. Stats., Chap. 533 (SB 1798)
Insurance--Gag Clauses	1996 Cal. Stats., Chap. 260 (SB 1847)
Insurance--Gag Clauses	1996 Cal. Stats., Chap. 1089 (AB 3013)
Insurance--Gag Clauses	1996 Cal. Stats., Chap. 1094 (SB 1805)
Insurance--General	1996 Cal. Stats., Chap. 864 (SB 1665)
Insurance--Health Insurance Purchasing	1996 Cal. Stats., Chap. 916 (SB 1559)
Insurance--Individual and Small Group	1996 Cal. Stats., Chap. 50 (SB 849)
Insurance--Individual and Small Group	1996 Cal. Stats., Chap. 359 and 360 (AB 8 and SB 37)
Insurance--Mandated Coverage	1996 Cal. Stats., Chap. 556 (SB 686)
Insurance--Medical Savings Accounts	1996 Cal. Stats., Chap. 954 (SB 38)
Insurance--Other Consumer Protections	1996 Cal. Stats., Chap. 534 (SB 1875)
Insurance—Other Consumer Protections	1996 Cal. Stats., Chap. 979 (AB 1663)
Insurance—Other Consumer Protections	1996 Cal. Stats., Chap. 1014 (AB 2649)
Insurance—Other Consumer Protections	1996 Cal. Stats., Chap. 1024 (SB 1547)
Insurance—Other Consumer Protections	1996 Cal. Stats., Chap. 1091 (AB 3251)
Insurance—Preexisting Conditions	1996 Cal. Stats., Chap. 544 (AB 3142)
Insurance—State Sponsored Insurance	1996 Cal. Stats., Chap. 792 (SB 661)

Legal and Ethical Issues	1996 Cal. Stats., Chap. 790 (AB 2125)
Medicaid	1996 Cal. Stats., Chap. 74 (AB 2804)
Medicaid	1996 Cal. Stats., Chap. 197 (AB 3483)
Medicaid	1996 Cal. Stats., Chap. 198 (AB 3484)
Medicaid	1996 Cal. Stats., Chap. 199 (AB 3487)
Medicaid	1996 Cal. Stats., Chap. 529 (SB 1636)
Medicaid	1996 Cal. Stats., Chap. 534 (SB 1875)
Medicaid	1996 Cal. Stats., Chap. 1099 (AB 1184)
Medicaid	1996 Cal. Stats., Chap. 1114 (SB 1664)
Pharmaceuticals	1996 Cal. Stats., Chap. 13 (SB 668)
Pharmaceuticals	1996 Cal. Stats., Chap. 197 (AB 3483)
Pharmaceuticals	1996 Cal. Stats., Chap. 455 (AB 1077)
Pharmaceuticals	1996 Cal. Stats., Chap. 527 (SB 1596)
Prenatal Care and Infant Mortality	1996 Cal. Stats., Chap. 199 (AB 3487)
Prevention and Primary Care	1996 Cal. Stats., Chap. 148 (AB 3097)
Prevention and Primary Care	1996 Cal. Stats., Chap. 197 (AB 3483)
Prevention and Primary Care	1996 Cal. Stats., Chap. 199 (AB 3487)
Providers	1996 Cal. Stats., Chap. 158 (SB 1738)
Providers	1996 Cal. Stats., Chap. 148 (AB 3097)
Providers	1996 Cal. Stats., Chap. 13 (SB 668)
Providers	1996 Cal. Stats., Chap. 455 (AB 1077)
Providers	1996 Cal. Stats., Chap. 527 (SB 1596)
Providers	1996 Cal. Stats., Chap. 533 (SB 1798)
Providers	1996 Cal. Stats., Chap. 817 (AB 2443)
Providers	1996 Cal. Stats., Chap. 902 (SB 2098)
Providers	1996 Cal. Stats., Chap. 1012 (AB 2577)
Providers	1996 Cal. Stats., Chap. 1089 (AB 3013)
Providers	1996 Cal. Stats., Chap. 1094 (SB 1805)
Telemedicine	1996 Cal. Stats., Chap. 864 (SB 1665)
Telemedicine	1996 Cal. Stats., Chap. 902 (SB 2098)
Women's Health	1996 Cal. Stats., Chap. 50 (SJR 52)
Women's Health	1996 Cal. Stats., Chap. 197 (AB 3483)
Women's Health	1996 Cal. Stats., Chap. 790 (AB 2125)
Women's Health	1996 Cal. Stats., Chap. 1100 (AB 1291)

Colorado

Immunization	1996 Colo. Sess. Laws, Chap. 127 (HB 1176)
Insurance--Access to Providers	1996 Colo. Sess. Laws, Chap. 153 (HB 1082)
Insurance--Gag Clauses	1996 Colo. Sess. Laws, Chap. 122 (HB 1216)
Insurance--General	1996 Colo. Sess. Laws, Chap. 241 (HB 1208)
Insurance--Health Insurance Purchasing	1996 Colo. Sess. Laws, Chap. 136 (HB 1264)
Insurance--Individual and Small Group	1996 Colo. Sess. Laws, Chap. 102 (SB 184)
Insurance--Individual and Small Group	1996 Colo. Sess. Laws, Chap. 113 (HB 1232)
Insurance--Mandated Coverage	1996 Colo. Sess. Laws, Chap. 33 (HB 1241)
Medicaid	1996 Colo. Sess. Laws, Chap. 172 (HB 1188)
Newborn Screening	1996 Colo. Sess. Laws, Chap. 222 (HB 1030)
Providers	1996 Colo. Sess. Laws, Chap. 103 (SB 49)
Providers	1996 Colo. Sess. Laws, Chap. 153 (HB 1082)
Providers	1996 Colo. Sess. Laws, Chap. 300 (SB 100)
Special Health Care Needs and Diseases	1996 Colo. Sess. Laws, Chap. 265 (SB 178)

Connecticut

Access and Reform	1996 Conn. Acts, P.A. 96-238 (SB 72)
Coordination	1996 Conn. Acts, P.A. 96-238 (SB 72)
Data Quality	1996 Conn. Acts, P.A. 96-160 (SB 28)
Injury Prevention	1996 Conn. Acts, P.A. 96-167 (HB 5351)
Insurance--Access to Providers	1996 Conn. Acts, P.A. 96-227 (HB 5364)
Insurance--Individual and Small Group	1996 Conn. Acts, P.A. 96-234 (HB 5645)
Insurance--Mandated Coverage	1996 Conn. Acts, P.A. 96-177 (SB 330)
Insurance--Mandated Coverage	1996 Conn. Acts, P.A. 96-185 (SB 68)
Insurance--Maternity Issues	1996 Conn. Acts, P.A. 96-177 (SB 330)
Insurance--Other Consumer Protections	1996 Conn. Acts, P.A. 96-067 (HB 5583)
Insurance--State Sponsored Insurance	1996 Conn. Acts, P.A. 96-187 (HB 5024)
Medicaid	1996 Conn. Acts, P.A. 96-268 (SB 675)
Prenatal Care and Infant Mortality	1996 Conn. Acts, P.A. 96-160 (SB 28)
Prevention and Primary Care	1996 Conn. Acts, P.A. 96-229 (HB 5794)
Providers	1996 Conn. Acts, P.A. 96-019 (HB 5023)
Providers	1996 Conn. Acts, P.A. 96-227 (HB 5364)
School Health	1996 Conn. Acts, P.A. 96-229 (HB 5794)
Special Health Care Needs and Diseases	1996 Conn. Acts, P.A. 96-185 (SB 68)
Special Health Care Needs and Diseases	1996 Conn. Acts, P.A. 96-229 (HB 5794)
Telemedicine	1996 Conn. Acts, P.A. 96-148 (SB 225)
Women's Health	1996 Conn. Acts, P.A. 96-177 (SB 330)
Women's Health	1996 Conn. Acts, P.A. 96-238 (SB 72)

Delaware

Coordination	Vol. 70 Del. Laws, Sen. Jt. Res. 19
Emergency Medical Services	Vol. 70 Del. Laws, Chap. 453 (HB 433)
Financing	Vol. 70 Del. Laws, Chap. 472 (SB 405)
Health Promotion	Vol. 70 Del. Laws, H. Res. 86
Health Promotion	Vol. 70 Del. Laws, Chap. 472 (SB 405)
Insurance—Gag Clauses	Vol. 70 Del. Laws, Chap. 537 (SB 449)
Insurance—General	Vol. 70 Del. Laws, H. Res. 94
Insurance—Individual and Small Group	Vol. 70 Del. Laws, Chap. 104 (HB 240)
Insurance—Mandated Coverage	Vol. 70 Del. Laws, Sen. Concur. Res. 73
Insurance—Mandated Coverage	Vol. 70 Del. Laws, H. Res. 85
Insurance—Maternity Issues	Vol. 70 Del. Laws, H. Conc. Res. 61
Insurance—Maternity Issues	Vol. 70 Del. Laws, Sen. Concur. Res. 73
Insurance—Other Consumer Protections	Vol. 70 Del. Laws, Chap. 194 (HB 310)
Insurance—Domestic Violence	Vol. 70 Del. Laws, Chap. 250 (SB 128)
Insurance—Domestic Violence	Vol. 70 Del. Laws, Chap. 510 (SB 433)
Legal and Ethical Issues	Vol. 70 Del. Laws, Chap. 250 (SB 128)
Legal and Ethical Issues	Vol. 70 Del. Laws, Chap. 510 (SB 433)
Minority Health	Vol. 70 Del. Laws, Chap. 516 (SB 418)
Pharmaceuticals	Vol. 70 Del. Laws, H. Res. 85
Prenatal Care and Infant Mortality	Vol. 70 Del. Laws, Sen. Concur. Res. 73
Prenatal Care and Infant Mortality	Vol. 70 Del. Laws, Chap. 520 (HB 626)
Prevention and Primary Care	Vol. 70 Del. Laws, Sen. Jt. Res. 19
Providers	Vol. 70 Del. Laws, Chap. 516 (SB 418)
Rural Health	Vol. 70 Del. Laws, Chap. 516 (SB 418)
School Health	Vol. 70 Del. Laws, Sen. Jt. Res. 19
Special Health Care Needs and Diseases	Vol. 70 Del. Laws, Sen. Jt. Res. 19
Women's Health	Vol. 70 Del. Laws, H. Res. 86
Women's Health	Vol. 70 Del. Laws, Chap. 472 (SB 405)

District of Columbia

Access and Reform	1996 D.C. Stats , Act 11-486 (Bill No. 11-96
Environmental Hazards	1996 D.C. Stats., Act 11-438 (Bill No. 11-640)
Insurance—General	1996 D.C. Stats., Act 11-172 (Bill No. 11-44)
Insurance—General	1996 D.C. Stats., Act 11-234 (Bill No. 11-390)
Insurance—General	1996 D.C. Stats., Act 11-524 (Bill No. 11-415)
Insurance—Maternity Issues	1996 D.C. Stats., Act 11-501 (Bill No. 11-598)
Insurance—Other Consumer Protections	1996 D.C. Stats., Act 11-228 (Bill No. 11-168)
Insurance—Other Consumer Protections	1996 D.C. Stats., Act 11-495 (Bill No. 11-442)
Legal and Ethical Issues	1996 D.C. Stats., Act 11-228 (Bill No. 11-168)
Prevention and Primary Care	1996 D.C. Stats., Act 11-486 (Bill No. 11-962)

Florida

Access and Reform	1996 Fla. Laws, Chap. 199 (SB 886)
Access and Reform	1996 Fla. Laws, Chap. 319 (SB 14)
Access and Reform	1996 Fla. Laws, Chap. 337 (HB 1813)
Access and Reform	1996 Fla. Laws, Chap. 403 (HB 555)
Coordination	1996 Fla. Laws, Chap. 199 (SB 886)
Coordination	1996 Fla. Laws, Chap. 403 (HB 555)
Coordination	1996 Fla. Laws, Chap. 420 (HB 2717)
Coordination	1996 Fla. Laws, Chap. 509 (HB 2005)
Data Quality	1996 Fla. Laws, Chap. 199 (SB 886)
Emergency Medical Services	1996 Fla. Laws, Chap. 223 (SB 910)
Emergency Medical Services	1996 Fla. Laws, Chap. 509 (HB 2005)
Health Promotion	1996 Fla. Laws, Chap. 217 (SB 322)
Health Promotion	1996 Fla. Laws, Chap. 282 (HB 397)
Health Promotion	1996 Fla. Laws, Sen. Res. 1824
Health Promotion	1996 Fla. Laws, Sen. Res. 2894 and H. Res. 9053
Health Promotion	1996 Fla. Laws, H. Res. 9057
Health Promotion	1996 Fla. Laws, H. Res. 9241
Immunization	1996 Fla. Laws, Chap. 195 (SB 1860)
Immunization	1996 Fla. Laws, Sen. Res. 2894 and H. Res. 9053
Injury Prevention	1996 Fla. Laws, Chap. 185 (SB 2370)
Injury Prevention	1996 Fla. Laws, Chap. 187 (SB 336)
Injury Prevention	1996 Fla. Laws, Chap. 246 (HB 341)
Injury Prevention	1996 Fla. Laws, H. Res. 9057
Insurance—Access to Providers	1996 Fla. Laws, Chap. 223 (SB 910)
Insurance—Access to Providers	1996 Fla. Laws, Chap. 279 (HB 1239)
Insurance—Individual and Small Group	1996 Fla. Laws, Chap. 319 (SB 14)
Insurance—Mandated Coverage	1996 Fla. Laws, Chap. 279 (HB 1239)
Insurance—Mandated Coverage	1996 Fla. Laws, Chap. 282 (HB 397)
Insurance—Maternity Issues	1996 Fla. Laws, Chap. 195 (SB 1860)
Insurance—Other Consumer Protections	1996 Fla. Laws, Chap. 180 (SB 742)
Insurance—Other Consumer Protections	1996 Fla. Laws, Chap. 391 (SB 2214)
Insurance—Preexisting Conditions	1996 Fla. Laws, Chap. 223 (SB 910)
Insurance—Preexisting Conditions	1996 Fla. Laws, Chap. 319 (SB 14)
Insurance—State Sponsored Insurance	1996 Fla. Laws, Chap. 337 (HB 1813)
Legal and Ethical Issues	1996 Fla. Laws, Chap. 179 (SB 474)
Legal and Ethical Issues	1996 Fla. Laws, Chap. 180 (SB 742)
Medicaid	1996 Fla. Laws, Chap. 175 (SB 1662)
Medicaid	1996 Fla. Laws, Chap. 199 (SB 886)
Medicaid	1996 Fla. Laws, Chap. 403 (HB 555)
Minority Health	1996 Fla. Laws, Chap. 292 (HB 437)
Newborn Screening	1996 Fla. Laws, Chap. 306 (HB 1105)
Pharmaceuticals	1996 Fla. Laws, Chap. 197 (HB 495)

Pharmaceuticals	1996 Fla. Laws, Chap. 296 (HB 537)
Prenatal Care and Infant Mortality	1996 Fla. Laws, Chap. 179 (SB 474)
Prevention and Primary Care	1996 Fla. Laws, Sen. Res. 1824
Providers	1996 Fla. Laws, Chap. 147 (SB 112)
Providers	1996 Fla. Laws, Chap. 197 (HB 495)
Providers	1996 Fla. Laws, Chap. 274 (HB 581)
Providers	1996 Fla. Laws, Chap. 279 (HB 1239)
Providers	1996 Fla. Laws, Chap. 296 (HB 537)
Providers	1996 Fla. Laws, Chap. 304 (HB 965)
Providers	1996 Fla. Laws, Chap. 403 (HB 555)
Rural Health	1996 Fla. Laws, Chap. 509 (HB 2005)
School Health	1996 Fla. Laws, Chap. 199 (SB 886)
School Health	1996 Fla. Laws, Chap. 217 (SB 322)
School Health	1996 Fla. Laws, Chap. 294 (HB 483)
Special Health Care Needs and Diseases	1996 Fla. Laws, Chap. 148 (SB 308)
Special Health Care Needs and Diseases	1996 Fla. Laws, Chap. 199 (SB 886)
Special Health Care Needs and Diseases	1996 Fla. Laws, Chap. 292 (HB 437)
Special Health Care Needs and Diseases	1996 Fla. Laws, Chap. 294 (HB 483)
Special Health Care Needs and Diseases	1996 Fla. Laws, Chap. 420 (HB 2717)
Special Health Care Needs and Diseases	1996 Fla. Laws, Sen. Res. 1824
Women's Health	1996 Fla. Laws, Chap. 223 (SB 910)
Women's Health	1996 Fla. Laws, Chap. 282 (HB 397)
Women's Health	1996 Fla. Laws, H. Res. 9241

Georgia

Emergency Medical Service	1996 Ga. Laws, p. 751 (H 1338)
Immunization	1996 Ga. Laws, p. 799 (H 844)
Insurance—Access to Providers	1996 Ga. Laws, p. 820 (S 592)
Insurance—Access to Providers	1996 Ga. Laws, p. 821 (H 1404)
Insurance—Gag Clauses	1996 Ga. Laws, p. 751 (H 1338)
Insurance—Maternity Issues	1996 Ga. Laws, p. 739 (S 482)
Insurance--Other Consumer Protections	1996 Ga. Laws, p. 751 (H 1338)
Medicaid	1996 Ga. Laws, p. 1037 (H 1265)
Pharmaceuticals	1996 Ga. Laws, p. 1037 (H 1265)
Providers	1996 Ga. Laws, p. 751 (H 1338)
Providers	1996 Ga. Laws, p. 820 (S 592)
Telemedicine	1996 Ga. Laws, p. 1039 (S 46)

Guam

Access and Reform	1996 Guam Laws, P.L. 23-035
Emergency Medical Services	1996 Guam Laws, P.L. 23-077
Insurance--General	1996 Guam Laws, P.L. 23-076
Insurance--State Sponsored Insurance	1996 Guam Laws, P.L. 23-076
Pharmaceuticals	1996 Guam Laws, P.L. 23-009
Pharmaceuticals	1996 Guam Laws, P.L. 23-123
Providers	1996 Guam Laws, P.L. 23-009
Providers	1996 Guam Laws, P.L. 23-123
Special Health Care Needs and Diseases	1996 Guam Laws, P.L. 23-076

Hawaii

Access and Reform	1996 Hawaii Sess. Laws, S. Res. 147
Coordination	1996 Hawaii Sess. Laws, Act 125 (HB 3498)
Coordination	1996 Hawaii Sess. Laws, Act 287 (HB 2800)
Data Quality	1996 Hawaii Sess. Laws, H. Res. 152
Financing	1996 Hawaii Sess. Laws, Act 259 (HB 3493)

	Health Promotion	1996 Hawaii Sess. Laws, S. Res. 151 and H. Res.
	Injury Prevention	1996 Hawaii Sess. Laws, H. Res. 79 and H. Concur. 74)
	Insurance--Other Consumer Protections	1996 Hawaii Sess. Laws, Act 274 (HB 3785)
	Legal and Ethical Issues	1996 Hawaii Sess. Laws, S. Res.83
	Legal and Ethical Issues	1996 Hawaii Sess. Laws, S. Res. 226
	Medicaid	1996 Hawaii Sess. Laws, Act 68 (HB 3461)
	Medicaid	1996 Hawaii Sess. Laws, Act 287 (HB 2800)
	Minority Health	1996 Hawaii Sess. Laws, H. Res. 152
	Minority Health	1996 Hawaii Sess. Laws, S. Res. 151 and H. Res. 152
	Newborn Screening	1996 Hawaii Sess. Laws, Act 259 (HB 3493)
	Pharmaceuticals	1996 Hawaii Sess. Laws, Act 287 (HB 2800)
	Pharmaceuticals	1996 Hawaii Sess. Laws, Act 292 (HB 2647)
	Pharmaceuticals	1996 Hawaii Sess. Laws, H. Res. 82
	Prenatal Care and Infant Mortality	1996 Hawaii Sess. Laws, H. Res. 82
	Prevention and Primary Care	1996 Hawaii Sess. Laws, H. Res. 152
	Prevention and Primary Care	1996 Hawaii Sess. Laws, S. Res. 151 and H. Res. 152
	Providers	1996 Hawaii Sess. Laws, Act 150 (SB 2532)
	Providers	1996 Hawaii Sess. Laws, Act 262 (SB 2522)
	Providers	1996 Hawaii Sess. Laws, Act 263 (SB 3198)
	Providers	1996 Hawaii Sess. Laws, Act 292 (HB 2647)
	School Health	1996 Hawaii Sess. Laws, Act 287 (HB 2800)
	Special Health Care Needs and Diseases	1996 Hawaii Sess. Laws, Act 125 (HB 3498)
	Special Health Care Needs and Diseases	1996 Hawaii Sess. Laws, Act 287 (HB 2800)
Idaho	Access and Reform	1996 Idaho Sess. Laws, H. Concur. Res. 45
	Access and Reform	1996 Idaho Sess. Laws, Chap. 59 (HB 446)
	Access and Reform	1996 Idaho Sess. Laws, Chap. 60 (HB 502)
	Access and Reform	1996 Idaho Sess. Laws, Chap. 410 (SB 1567)
	Coordination	1996 Idaho Sess. Laws, Chap. 26 (HB 535)
	Coordination	1996 Idaho Sess. Laws, Chap. 147 (SB 1439)
	Emergency Medical Services	1996 Idaho Sess. Laws, Chap. 26 (HB 535)
	Emergency Medical Services	1996 Idaho Sess. Laws, Chap. 147 (SB 1439)
	Financing	1996 Idaho Sess. Laws, Chap. 410 (SB 1567)
	Injury Prevention	1996 Idaho Sess. Laws, Chap. 147 (SB 1439)
	Insurance--General	1996 Idaho Sess. Laws, Chap. 53 (HB 413)
	Insurance--General	1996 Idaho Sess. Laws, Chap. 96 (HB 449)
	Insurance--General	1996 Idaho Sess. Laws, Sen. Concur. Res. 136
	Insurance—Individual and Small Group	1996 Idaho Sess. Laws, Chap. 124 (SB 1383)
	Insurance—Medical Savings Accounts	1996 Idaho Sess. Laws, H. Concur. Res. 45
	Insurance—Medical Savings Accounts	1996 Idaho Sess. Laws, Chap. 59 (HB 446)
	Insurance—Medical Savings Accounts	1996 Idaho Sess. Laws, Chap. 60 (HB 502)
	Insurance—Preexisting Conditions	1996 Idaho Sess. Laws, Chap. 124 (SB 1383)
	Insurance—Preexisting Conditions	1996 Idaho Sess. Laws, Chap. 145 (SB 1322)
	Legal and Ethical Issues	1996 Idaho Sess. Laws, Chap. 227 (H 553)
	Medicaid	1996 Idaho Sess. Laws, Chap. 338 (H 533)
	Prenatal Care and Infant Mortality	1996 Idaho Sess. Laws, Chap. 227 (H 553)
	Providers	Idaho Const. Amend. (Leg. Ref., SRJ 111), 1996 Gen. Election
	Special Health Care Needs and Diseases	1996 Idaho Sess. Laws, Chap. 124 (SB 1383)
	Special Health Care Needs and Diseases	1996 Idaho Sess. Laws, Chap. 145 (SB 1322)
Illinois	Access and Reform	1996 Ill. Laws, P.A. 89-486 (HB 3186)
	Access and Reform	1996 Ill. Laws, P.A. 89-628 (HB 3520)
	Access and Reform	1996 Ill. Laws, P.A. 89-646 (SB 1513)
	Access and Reform	1996 Ill. Laws, P.A. 89-667 (SB 1327)

	Coordination	1996 Ill. Laws, P.A. 89-507 (HB 2632)
	Data Quality	1996 Ill. Laws, P.A. 89-554 (HB 2587)
	Emergency Medical Services	1996 Ill. Laws, P.A. 89-516 (HB 3309)
	Emergency Medical Services	1996 Ill. Laws, P.A. 89-646 (SB 1513)
	Emergency Medical Services	1996 Ill. Laws, P.A. 89-667 (SB 1327)
	Financing	1996 Ill. Laws, P.A. 89-506 (HB 22)
	Financing	1996 Ill. Laws, P.A. 89-516 (HB 3309)
	Financing	1996 Ill. Laws, P.A. 89-646 (SB 1513)
	Insurance—Access to Providers	1996 Ill. Laws, P.A. 89-373 (SB 1246)
	Insurance—Health Insurance Purchasing	1996 Ill. Laws, P.A. 89-486 (HB 3186)
	Insurance—Health Insurance Purchasing	1996 Ill. Laws, P.A. 89-628 (HB 3520)
	Insurance—Maternity Issues	1996 Ill. Laws, P.A. 89-513 (HB 2557)
	Legal and Ethical Issues	1996 Ill. Laws, P.A. 89-646 (SB 1513)
	Medicaid	1996 Ill. Laws, P.A. 89-513 (HB 2557)
	Medicaid	1996 Ill. Laws, P.A. 89-517 (HB 3613)
	Prenatal Care and Infant Mortality	1996 Ill. Laws, P.A. 89-507 (HB 2632)
	Providers	1996 Ill. Laws, P.A. 89-373 (SB 1246)
	Providers	1996 Ill. Laws, P.A. 89-506 (HB 22)
	Providers	1996 Ill. Laws, P.A. 89-607 (HB 3618)
	Special Health Care Needs and Diseases	1996 Ill. Laws, P.A. 89-507 (HB 2632)
	Substance Abuse (Women and Infants)	1996 Ill. Laws, P.A. 89-507 (HB 2632)
	Substance Abuse (Women and Infants)	1996 Ill. Laws, P.A. 89-517 (HB 3613)
Indiana		
	Injury Prevention	1996 Ind. Acts, P.L. 249 (SB 18)
	Insurance—Access to Providers	1996 Ind. Acts, P.L. 192 (SB 392)
	Insurance—Access to Providers	1996 Ind. Acts, P.L. 195 (SB 378)
	Insurance—Access to Providers	1996 Ind. Acts, P.L. 331 (SB 191)
	Insurance—Gag Clauses	1996 Ind. Acts, P.L. 192 (SB 392)
	Insurance—General	1996 Ind. Acts, P.L. 186 (SB 356)
	Insurance—General	1996 Ind. Acts, P.L. 251 (HB 1289)
	Insurance—Individual and Small Group	1996 Ind. Acts, P.L. 190 (SB 117)
	Insurance—Individual and Small Group	1996 Ind. Acts, P.L. 193 (SB 118)
	Insurance—Maternity Issues	1996 Ind. Acts, P.L. 194 (HB 1075)
	Insurance—Medical Savings Accounts	1996 Ind. Acts, P.L. 66 (SB 122)
	Insurance—Preexisting Conditions	1996 Ind. Acts, P.L. 190 (SB 117)
	Insurance—Domestic Violence	1996 Ind. Acts, P.L. 188 (SB 306)
	Legal and Ethical Issues	1996 Ind. Acts, P.L. 219 (SB 176)
	Medicaid	1996 Ind. Acts, P.L. 108 (SB 175)
	Medicaid	1996 Ind. Acts, P.L. 114 (SB 414)
	Medicaid	1996 Ind. Acts, P.L. 115 (HB 1252)
	Medicaid	1996 Ind. Acts, P.L. 241 (HB 1219)
	Medicaid	1996 Ind. Acts, P.L. 246 (HB 1354)
	Pharmaceuticals	1996 Ind. Acts, P.L. 114 (SB 414)
	Providers	1996 Ind. Acts, P.L. 192 (SB 392)
	Providers	1996 Ind. Acts, P.L. 219 (SB 176)
	Special Health Care Needs and Diseases	1996 Ind. Acts, P.L. 112 (HB 1355)
	Special Health Care Needs and Diseases	1996 Ind. Acts, P.L. 246 (HB 1354)
	Telemedicine	1996 Ind. Acts, P.L. 180 (HB 1294)
Iowa		
	Coordination	1996 Iowa Acts, Chap. 1084 (SF 2307)
	Coordination	1996 Iowa Acts, Chap. 1156 (SF 2294)
	Coordination	1996 Iowa Acts, Chap. 1183 (HF 2427)
	Data Quality	1996 Iowa Acts, Chap. 1108 (SF 2218)

Emergency Medical Services	1996 Iowa Acts, Chap. 1061 (HF 523)
Environmental Hazards	1996 Iowa Acts, Chap. 1161 (SF 2301)
Financing	1996 Iowa Acts, Chap. 1106 (SF 2324)
Insurance—General	1996 Iowa Acts, Chap. 1169 (HF 2144)
Insurance—Maternity Issues	1996 Iowa Acts, Chap. 1202 (HF 2369)
Newborn Screening	1996 Iowa Acts, Chap. 1212 (SF 2448)
Prenatal Care and Infant Mortality	1996 Iowa Acts, Chap. 1212 (SF 2448)
Prenatal Care and Infant Mortality	1996 Iowa Acts, Chap. 1212 (SF 2448)
Prevention and Primary Care	1996 Iowa Acts, Chap. 1212 (SF 2448)
Providers	1996 Iowa Acts, Chap. 1128 (SF 2171)
Providers	1996 Iowa Acts, Chap. 1158 (SF 2157)
Special Health Care Needs and Diseases	1996 Iowa Acts, Chap. 1084 (SF 2307)
Special Health Care Needs and Diseases	1996 Iowa Acts, Chap. 1183 (HF 2427)
Substance Abuse (Women and Infants)	1996 Iowa Acts, Chap. 1092 (SF 2410)

Kansas

Immunization	1996 Kan. Sess. Laws, Chap. 229 (HB 2900)
Insurance—Individual and Small Group	1996 Kan. Sess. Laws, Chap. 182 (SB 529)
Insurance—Maternity Issues	1996 Kan. Sess. Laws, Chap. 96 (SB 573)
Insurance—Other Consumer Protections	1996 Kan. Sess. Laws, Chap. 169 (SB 477)
Insurance—Preexisting Conditions	1996 Kan. Sess. Laws, Chap. 182 (SB 529)
Insurance—State Sponsored Insurance	1996 Kan. Sess. Laws, Chap. 98 (SB 441)
Insurance—State Sponsored Insurance	1996 Kan. Sess. Laws, Chap. 130 (S 593)
Medicaid	1996 Kan. Sess. Laws, Chap. 96 (SB 573)
Medicaid	1996 Kan. Sess. Laws, Chap. 130 (S 593)
Medicaid	1996 Kan. Sess. Laws, Chap. 210 (SB 625)
Minority Health	1996 Kan. Sess. Laws, Chap. 210 (SB 625)
Oral Health	1996 Kan. Sess. Laws, Chap. 210 (SB 625)
Pharmaceuticals	1996 Kan. Sess. Laws, Chap. 179 (SB 152)
Providers	1996 Kan. Sess. Laws, Chap. 91 (HB 2867)
Providers	1996 Kan. Sess. Laws, Chap. 169 (SB 477)
Providers	1996 Kan. Sess. Laws, Chap. 179 (SB 152)
Providers	1996 Kan. Sess. Laws, Chap. 210 (SB 625)

Kentucky

Access and Reform	1996 Ky. Acts, Chap. 371 (SB 343)
Child Fatalities	1996 Ky. Acts, Chap. 347 (HB 94)
Coordination	1996 Ky. Acts, Chap. 197 (HJR 80)
Environmental Hazards	1996 Ky. Acts, Chap. 168 (SB 182)
Financing	1996 Ky. Acts, Chap. 26 (HB 363)
Financing	1996 Ky. Acts, Chap. 110 (HB 397)
Immunization	1996 Ky. Acts, Chap. 306 (HB 588)
Insurance--Access to Providers	1996 Ky. Acts, Chap. 187 (HB 782)
Insurance--General	1996 Ky. Acts, Chap. 348 (SB 400)
Insurance--General	1996 Ky. Acts, Chap. 365 (HB 300)
Insurance--General	1996 Ky. Acts, Chap. 371 (SB 343)
Insurance--Mandated Coverage	1996 Ky. Acts, Chap. 114 (HB 504)
Insurance--Maternity Issues	1996 Ky. Acts, Chap. 88 (HB 186)
Insurance--Other Consumer Protections	1996 Ky. Acts, Chap. 286 (SB 285)
Insurance--Other Consumer Protections	1996 Ky. Acts, Chap. 353 (SB 49)
Insurance--Preexisting Conditions	1996 Ky. Acts, Chap. 371 (SB 343)
Medicaid	1996 Ky. Acts, Chap. 304 (HB 494)
Medicaid	1996 Ky. Acts, Chap. 353 (SB 49)
Medicaid	1996 Ky. Acts, Chap. 371 (SB 343)
Pharmaceuticals	1996 Ky. Acts, Chap. 342 (HB 358)

Prevention and Primary Care	1996 Ky. Acts, Chap. 186 (SCR 96)
Providers	1996 Ky. Acts, Chap. 26 (HB 363)
Providers	1996 Ky. Acts, Chap. 110 (HB 397)
Providers	1996 Ky. Acts, Chap. 187 (HB 782)
Providers	1996 Ky. Acts, Chap. 304 (HB 494)
Providers	1996 Ky. Acts, Chap. 342 (HB 358)
Providers	1996 Ky. Acts, Chap. 348 (SB 400)
Providers	1996 Ky. Acts, Chap. 371 (SB 343)
Special Health Care Needs and Diseases	1996 Ky. Acts, Chap. 221 (HB 159)
Special Health Care Needs and Diseases	1996 Ky. Acts, Chap. 336 (HB 611)
Women's Health	1996 Ky. Acts, Chap. 114 (HB 504)

Louisiana

Access and Reform	1996 La. Acts, P.A. 11 (HB 200)
Coordination	1996 La. Acts, Sen. Concur. Res. 22
Financing	1996 La. Acts, P.A. 27 (HB 84)
Financing	1996 La. Acts, Sen. Concur. Res. 66
Insurance--General	1996 La. Acts, H. Concur. Res. 28
Insurance--General	1996 La. Acts, P.A. 71 (SB 180)
Insurance--Medical Savings Accounts	1996 La. Acts, P.A. 11 (HB 200)
Legal and Ethical Issues	1996 La. Acts, H. Concur. Res. 52
Medicaid	1996 La. Acts, H. Concur. Res. 42
Pharmaceuticals	1996 La. Acts, Sen. Concur. Res. 52
Prenatal Care and Infant Mortality	1996 La. Acts, Sen. Concur. Res. 22
Special Health Care Needs and Diseases	1996 La. Acts, P.A. 27 (HB 84)
Special Health Care Needs and Diseases	1996 La. Acts, H. Concur. Res. 42
Women's Health	1996 La. Acts, H. Concur. Res. 52

Maine

Access and Reform	1996 Maine Laws, Chap. 598 (LD 1722)
Access and Reform	1996 Maine Laws, Chap. 653 (LD 1788)
Access and Reform	1996 Maine Laws, Chap. 673 (LD 1882)0
Data Quality	1996 Maine Laws, Chap. 653 (LD 1788)
Environmental Hazards	1996 Maine Laws, Chap. 572 (LD 1445)
Financing	1996 Maine Laws, Chap. 653 (LD 1788)
Financing	1996 Maine Laws, Chap. 697 (LD 1764)
Insurance--Access to Providers	1996 Maine Laws, Chap. 617 (LD 1385)
Insurance--Gag Clauses	1996 Maine Laws, Chap. 673 (LD 1882)
Insurance--Health Insurance Purchasing	1996 Maine Laws, Chap. 673 (LD 1882)
Insurance--Mandated Coverage	1996 Maine Laws, Chap. 592 (LD 1702)
Insurance--Mandated Coverage	1996 Maine Laws, Chap. 617 (LD 1385)
Insurance--Maternity Issues	1996 Maine Laws, Chap. 615 (LD 1732)
Insurance--Other Consumer Protections	1996 Maine Laws, Chap. 673 (LD 1882)
Insurance--Preexisting Conditions	1996 Maine Laws, Chap. 673 (LD 1882)
Medicaid	1996 Maine Laws, Chap. 653 (LD 1759)
Medicaid	1996 Maine Laws, Chap. 675 (LD 271)
Medicaid	1996 Maine Laws, Chap. 692 (LD 1812)
Pharmaceuticals	1996 Maine Laws, Chap. 665 (LD 1759)
Pharmaceuticals	1996 Maine Laws, Chap. 671 (LD 1852)
Pharmaceuticals	1996 Maine Laws, Chap. 673 (LD 1882)
Prevention and Primary Care	1996 Maine Laws, Chap. 598 (LD 1722)
Providers	1996 Maine Laws, Chap. 606 (LD 1814)
Providers	1996 Maine Laws, Chap. 617 (LD 1385)
Providers	1996 Maine Laws, Chap. 653 (LD 1788)

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Providers	1996 Maine Laws, Chap. 671 (LD 1852)
Special Health Care Needs and Diseases	1996 Maine Laws, Chap. 697 (LD 1764)
Women's Health	1996 Maine Laws, Chap. 617 (LD 1385)
Maryland	
Access and Reform	1996 Md. Laws, Chap. 335 (HB 1330)
Access and Reform	1996 Md. Laws, Chap. 549 (HB 1390)
Emergency Medical Services	1996 Md. Laws, Chap. 503 (HB 859)
Financing	1996 Md. Laws, Chap. 273 (HB 798)
Health Promotion	1996 Md. Laws, Chap. 365 (SB 59)
Injury Prevention	1996 Md. Laws, Chaps. 401 and 402 (SB 473/HB 897)
Insurance--Gag Clauses	1996 Md. Laws, Chap. 548 (HB 1374)
Insurance--General	1996 Md. Laws, Chap. 425 (HB 10)
Insurance--Individual and Small Group	1996 Md. Laws, Chap. 288 (HB 957)
Insurance--Individual and Small Group	1996 Md. Laws, Chap. 425 (HB 10)
Insurance—Mandated Coverage	1996 Md. Laws, Chap. 375 and 376 (SB 181/HB 119)
Insurance—Maternity Issues	1996 Md. Laws, Chap. 396 and 397 (SB 433/HB 1271)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 47 (HB 245)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 503 (HB 859)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 529 (HB 1207)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 548 (HB 1374)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 549 (HB 1390)
Insurance—Other Consumer Protections	1996 Md. Laws, Chap. 647 (HB 1148)
Medicaid	1996 Md. Laws, Chap. 102 (SB 104)
Medicaid	1996 Md. Laws, Chap. 352 (SB 750)
Medicaid	1996 Md. Laws, Chap. 352 and 102 (SB 750/HB 104)
Medicaid	1996 Md. Laws, Chap. 549 (HB 1390)
Pharmaceuticals	1996 Md. Laws, Chap. 102 (SB 104)
Prevention and Primary Care	1996 Md. Laws, Chap. 335 (HB 1330)
Prevention and Primary Care	1996 Md. Laws, Chap. 352 (SB 750)
Prevention and Primary Care	1996 Md. Laws, Chap. 549 (HB 1390)
Providers	1996 Md. Laws, Chap. 14 (SB 68)
Providers	1996 Md. Laws, Chap. 365 (SB 59)
Providers	1996 Md. Laws, Chap. 503 (HB 859)
Providers	1996 Md. Laws, Chap. 529 (HB 1207)
Providers	1996 Md. Laws, Chap. 549 (HB 1390)
Providers	1996 Md. Laws, Chaps.580 and 579 (HB 863/SB 392)
Women's Health	1996 Md. Laws, Chap. 365 (SB 59)
Women's Health	1996 Md. Laws, Chap. 375 and 376 (SB 181/HB 119)
Massachusetts	
Access and Reform	1996 Mass. Acts, Chap. 147 (HB 6004)
Access and Reform	1996 Mass. Acts, Chap. 203 (HB 6107)
Access and Reform	1996 Mass. Acts, Chap. 338 (HB 5478)
Data Quality	1996 Mass. Acts, Chap. 307 (HB 5662)
Financing	1996 Mass. Acts, Chap. 203 (HB 6107)
Immunization	1996 Mass. Acts, Chap. 334 (HB 5791)
Injury Prevention	1996 Mass. Acts, Chap. 144 (SB 1318)
Injury Prevention	1996 Mass. Acts, Chap. 214 (HB 1925)
Injury Prevention	1996 Mass. Acts, Chap. 303 (HB 5761)
Insurance—Gag Clauses	1996 Mass. Acts, Chap. 8 (HB 5347)
Insurance—General	1996 Mass. Acts, Chap. 297 (HB 6231)
Insurance—Other Consumer Protections	1996 Mass. Acts, Chap. 8 (HB 5347)
Insurance—Preexisting Conditions	1996 Mass. Acts, Chap. 297 (HB 6231)
Insurance—State Sponsored Insurance	1996 Mass. Acts, Chap. 203 (HB 6107)

Medicaid	1996 Mass. Acts, Chap. 203 (HB 6107)
Minority Health	1996 Mass. Acts, Chap. 147 (HB 6004)
Pharmaceuticals	1996 Mass. Acts, Chap. 203 (HB 6107)
Prevention and Primary Care	1996 Mass. Acts, Chap. 147 (HB 6004)
Providers	1996 Mass. Acts, Chap. 307 (HB 5662)
Michigan	
Access and Reform	1996 Mich. Pub. Acts, Act 352 (SB 847)
Coordination	Exec. Reorg. Ord. No. 1996-1
Coordination	1996 Mich. Pub. Acts, Act 352 (SB 847)
Data Quality	1996 Mich. Pub. Acts, Act 352 (SB 847)
Health Promotion	1996 Mich. Pub. Acts, Act 352 (SB 847)
Immunization	1996 Mich. Pub. Acts, Act 399 (HB 5094)
Immunization	1996 Mich. Pub. Acts, Act 540 (HB 5477)
Injury Prevention	1996 Mich. Pub. Acts, Act 574 (HB 5847)
Insurance—Access to Providers	1996 Mich. Pub. Acts, Act 515 (HB 5570)
Insurance—Individual and Small Group	1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573, HB 5571, SB 1166)
Insurance—Other Consumer Protections	1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573, HB 5571, SB 1166)
Insurance—Other Consumer Protections	1996 Mich. Pub. Acts, Act 518 (HB 5574)
Insurance—Preexisting Conditions	1996 Mich. Pub. Acts, Acts 472, 516 and 547 (HB 5573, HB 5571, SB 1166)
Legal and Ethical Issues	1996 Mich. Pub. Acts, Act 287 (HB 5741)
Legal and Ethical Issues	1996 Mich. Pub. Acts, Act 304 (SB 598)
Medicaid	1996 Mich. Pub. Acts, Act 352 (SB 847)
Prenatal Care and Infant Mortality	1996 Mich. Pub. Acts, Act 352 (SB 847)
Providers	1996 Mich. Pub. Acts, Act 355 (S 432)
School Health	1996 Mich. Pub. Acts, Act 287 (HB 5741)
School Health	1996 Mich. Pub. Acts, Act 352 (SB 847)
Special Health Care Needs and Diseases	1996 Mich. Pub. Acts, Act 352 (SB 847)
Substance Abuse (Women and Infants)	1996 Mich. Pub. Acts, Act 581 (HB 6140)
Women's Health	1996 Mich. Pub. Acts, Act 352 (SB 847)
Minnesota	
Data Quality	1996 Minn. Laws, Chap. 440 (SF 2410)
Immunization	1996 Minn. Laws, Chap. 451 (HF 1584)
Immunization	1996 Minn. Laws, Chap. 465 (HF 219)
Injury Prevention	1996 Minn. Laws, Chap. 396 (HF 2834)
Insurance—Mandated Coverage	1996 Minn. Laws, Chap. 446 (SF 1980)
Insurance—Mandated Coverage	1996 Minn. Laws, Chap. 465 (HF 219)
Insurance—Maternity Issues	1996 Minn. Laws, Chap. 335 (HF 2008)
Insurance—Other Consumer Protections	1996 Minn. Laws, Chap. 304 (HF 2044)
Insurance—Domestic Violence	1996 Minn. Laws, Chap. 278 (SF 1815)
Insurance—State Sponsored Insurance	1996 Minn. Laws, Chap. 451 (HF 1584)
Medicaid	1996 Minn. Laws, Chap. 440 (SF 2410)
Medicaid	1996 Minn. Laws, Chap. 451 (HF 1584)
Minority Health	1996 Minn. Laws, Chap. 451 (HF 1584)
Newborn Screening	1996 Minn. Laws, Chap. 451 (HF 1584)
Pharmaceuticals	1996 Minn. Laws, Chap. 451 (HF 1584)
Prenatal Care and Infant Mortality	1996 Minn. Laws, Chap. 440 (SF 2410)
Prevention and Primary Care	1996 Minn. Laws, Chap. 451 (HF 1584)
Providers	1996 Minn. Laws, Chap. 318 (HF 2558)
Providers	1996 Minn. Laws, Chap. 395 (SF 2849)
Rural Health	1996 Minn. Laws, Chap. 395 (SF 2849)
Special Health Care Needs and Diseases	1996 Minn. Laws, Chap. 451 (HF 1584)

Mississippi

Access and Reform	1996 Miss. Laws, Chap. 491 (H 1057)
Access and Reform	1996 Miss. Laws, Chap. 496 (H 1187)
Coordination	1996 Miss. Laws, Chap. 476 (HB 87)
Financing	1996 Miss. Laws, Chap. 496 (H 1187)
Financing	1996 Miss. Laws, Chap. 505 (S 2031)
Injury Prevention	1996 Miss. Laws, Chap. 545 (HB 1123)
Insurance—General	1996 Miss. Laws, Chap. 342 and 463 (HB 1276 and HB 1421)
Insurance—Medical Savings Accounts	1996 Miss. Laws, Chap. 491 (H 1057)
Medicaid	1996 Miss. Laws, H. Concur. Res. 198
Medicaid	1996 Miss. Laws, Chap. 496 (H 1187)
Medicaid	1996 Miss. Laws, Chap. 518 (S 2759)
Pharmaceuticals	1996 Miss. Laws, Chap. 578 (S 2759)
Prevention and Primary Care	1996 Miss. Laws, Chap. 440 (SB 2573)
Providers	1996 Miss. Laws, Chap. 496 (H 1187)
School Health	1996 Miss. Laws, Chap. 440 (SB 2573)
Special Health Care Needs and Diseases	1996 Miss. Laws, Chap. 476 (HB 87)
Special Health Care Needs and Diseases	1996 Miss. Laws, Chap. 505 (S 2031)

Missouri

Immunization	1996 Mo. Laws, p. 377 (HB 904)
Insurance—Maternity Issues	1996 Mo. Laws, p. 770 (HB 1069)
Providers	1996 Mo. Laws, p. 701 (HB 999)

Nebraska

Coordination	1996 Neb. Laws, L.B. 1044
Financing	1996 Neb. Laws, L.B. 1188
Medicaid	1996 Neb. Laws, L.B. 1155
Prevention and Primary Care	1996 Neb. Laws, L.B. 1155
Providers	1996 Neb. Laws, L.B. 414
Providers	1996 Neb. Laws, L.B. 1155
Providers	1996 Neb. Laws, L.B. 1188

New Hampshire

Emergency Medical Services	1996 N.H. Laws, Chap. 274 (SB 578)
Injury Prevention	1996 N.H. Laws, Chap. 19 (HB 1146)
Insurance--Gag Clauses	1996 N.H. Laws, Chap. 149 (HB 1459)
Insurance--General	1996 N.H. Laws, Chap. 134 (HB 1613)
Insurance--Mandated Coverage	1996 N.H. Laws, Chap. 131 (HB 1431)
Insurance--Mandated Coverage	1996 N.H. Laws, Chap. 193 (SB 590)
Insurance--Maternity Issues	1996 N.H. Laws, Chap. 75 (HB 1352)
Insurance-- Domestic Violence	1996 N.H. Laws, Chap. 40 (HB 1211)
Insurance--State Sponsored Insurance	1996 N.H. Laws, Chap. 119 (SB 541)
Medicaid	1996 N.H. Laws, Chap. 123 (HB 1522)
Newborn Screening	1996 N.H. Laws, Chap. 75 (HB 1352)
Prevention and Primary Care	1996 N.H. Laws, Chap. 81 (HB 1509)
Prevention and Primary Care	1996 N.H. Laws, Chap. 146 (HB 1306)
Prevention and Primary Care	1996 N.H. Laws, Chap. 193 (SB 590)
Prevention and Primary Care	1996 N.H. Laws, Chap. 290 (SB 656)
Providers	1996 N.H. Laws, Chap. 81 (HB 1509)
Providers	1996 N.H. Laws, Chap. 110 (HB 1586)
Providers	1996 N.H. Laws, Chap. 146 (HB 1306)
Providers	1996 N.H. Laws, Chap. 277 (SB 599)
Providers	1996 N.H. Laws, Chap. 299 (SB 4)
School Health	1996 N.H. Laws, Chap. 277 (SB 599)

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Special Health Care Needs and Diseases	1996 N.H. Laws, Chap. 193 (SB 590)
Substance Abuse (Women and Infants)	1996 N.H. Laws, Chap. 252 (HB 1576)
New Jersey	
Access and Reform	1996 N.J. Laws, Chap. 28 (AB 1532)
Access and Reform	1996 N.J. Laws, Chap. 29 (AB 1590)
Emergency Medical Services	1996 N.J. Laws, Chap. 136 (AB 1554)
Financing	1996 N.J. Laws, Chap. 28 (AB 1532)
Injury Prevention	1996 N.J. Laws, Chap. 15 (SB 662)
Insurance—Maternity Issues	1996 N.J. Laws, Sen. Res. 8
Insurance—Other Consumer Protections	1996 N.J. Laws, Chap. 126 (SB 695)
Insurance—State Sponsored Insurance	1996 N.J. Laws, Chap. 8 (SB 627)
Insurance—State Sponsored Insurance	1996 N.J. Laws, Chap. 29 (AB 1590)
Legal and Ethical Issues	1996 N.J. Laws, Chap. 126 (SB 695)
Medicaid	1996 N.J. Laws, Chap. 42 (SB 3)
Pharmaceuticals	1996 N.J. Laws, Sen. Res. 20
Providers	1996 N.J. Laws, Chap. 28 (AB 1532)
School Health	1996 N.J. Laws, Chap. 42 (SB 3)
Special Health Care Needs and Diseases	1996 N.J. Laws, Chap. 42 (SB 3)
New Mexico	
Access and Reform	1996 N.M. Laws, H. Jt. Mem. 20
Access and Reform	1996 N.M. Laws, Chap. 29 (HB 298)
Access and Reform	1996 N.M. Laws, Sen. Jt. Res. 31
Emergency Medical Services	1996 N.M. Laws, Sen. Jt. Res. 31
Emergency Medical Services	1996 N.M. Laws, Sen. Jt. Mem. 32
Financing	1996 N.M. Laws, H. Jt. Mem. 20
Financing	1996 N.M. Laws, Chap. 29 (HB 298)
Insurance—General	1996 N.M. Laws, H. Jt. Mem. 20
Insurance—Other Consumer Protections	1996 N.M. Laws, Sen. Jt. Mem. 28
Insurance—Other Consumer Protections	1996 N.M. Laws, Sen. Jt. Res. 31
Medicaid	1996 N.M. Laws, H. Jt. Mem. 8
Medicaid	1996 N.M. Laws, Sen. Jt. Mem. 28
Medicaid	1996 N.M. Laws, Sen. Jt. Mem. 32
Medicaid	1996 N.M. Laws, Sen. Jt. Mem. 50
Medicaid	1996 N.M. Laws, Chap. 70 (SB 124)
Providers	1996 N.M. Laws, Sen. Jt. Mem. 36
Providers	1996 N.M. Laws, Sen. Jt. Mem. 63
Rural Health	1996 N.M. Laws, Sen. Jt. Res. 31
School Health	1996 N.M. Laws, Chap. 62 (HB 29)
Special Health Care Needs and Diseases	1996 N.M. Laws, Sen. Jt. Mem. 48
Telemedicine	1996 N.M. Laws, H. Jt. Mem. 21
New York	
Access and Reform	1996 N.Y. Laws, Chap. 253 (S 7537-A)
Access and Reform	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Data Quality	1996 N.Y. Laws, Chap. 279 (S 7884)
Environmental Hazards	1996 N.Y. Laws, Chap. 279 (S 7884)
Financing	1996 N.Y. Laws, Chap. 253 (S 7537-A)
Financing	1996 N.Y. Laws, Chap. 279 (S 7884)
Financing	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Immunization	1996 N.Y. Laws, Chap. 61 (S 314-A)
Immunization	1996 N.Y. Laws, Chap. 62 (S 468)
Injury Prevention	1996 N.Y. Laws, Chap. 16 (S 5753)
Injury Prevention	1996 N.Y. Laws, Chap. 26 (S 380)
Injury Prevention	1996 N.Y. Laws, Chap. 156 (S 193-B)

Injury Prevention	1996 N.Y. Laws, Chap. 244 (S 6237-A)
Injury Prevention	1996 N.Y. Laws, Chap. 372 (S 4857)
Injury Prevention	1996 N.Y. Laws, Chap. 585 (S 7710)
Injury Prevention	1996 N.Y. Laws, Chap. 656 (S 339-A)
Insurance--Gag Clauses	1996 N.Y. Laws, Chap. 705 (S 7553)
Insurance--General	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Insurance--Individual and Small Group	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Insurance--Maternity Issues	1996 N.Y. Laws, Chap. 56 (S 5742-A)
Insurance--Other Consumer Protections	1996 N.Y. Laws, Chap. 497 (S 4293-D)
Insurance--Other Consumer Protections	1996 N.Y. Laws, Chap. 705 (S 7553)
Insurance-- Domestic Violence	1996 N.Y. Laws, Chap. 174 (A 2769-E)
Legal and Ethical Issues	1996 N.Y. Laws, Chap. 497 (S 4293-D)
Legal and Ethical Issues	1996 N.Y. Laws, Chap. 612 (S 6053-B)
Medicaid	1996 N.Y. Laws, Chap. 47 (5756-A)
Medicaid	1996 N.Y. Laws, Chap. 350 (S 7650-A)
Medicaid	1996 N.Y. Laws, Chap. 526 (S 6615-A)
Medicaid	1996 N.Y. Laws, Chap. 649 (A 11329)
Minority Health	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Prenatal Care and Infant Mortality	1996 N.Y. Laws, Chap. 649 (A 11329)
Prevention and Primary Care	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Providers	1996 N.Y. Laws, Chap. 253 (S 7537-A)
Providers	1996 N.Y. Laws, Chaps. 639 and 640 (A 11330 and A 11341)
Women's Health	1996 N.Y. Laws, Chap. 279 (S 7884)
North Carolina	
Access and Reform	1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part XVI (SB 46, Part XVI)
Access and Reform	1996 N.C. Sess. Laws, Chap. 634 (HB 1149)
Child Fatalities	1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part III (SB 46, Part III)
Coordination	1996 N.C. Sess. Laws, Chap. 690 (SB 709)
Insurance—Access to Providers	1996 N.C. Sess. Laws, Chap. 713 (SB 855)
Insurance—General	1996 N.C. Sess. Laws, Chap. 713 (SB 855)
Insurance—Individual and Small Group	1996 N.C. Sess. Laws, Chap. 669 (HB 1202)
Medicaid	1996 N.C. Sess. Laws, Extra Sess., Chaps. 17 and 18 (HB 53 and SB 46)
Medicaid	1996 N.C. Sess. Laws, Second Extra Sess., Chap. 18 (HB 53, Sec. 24)
Providers	1996 N.C. Sess. Laws, Extra Sess., Chap. 17, Part XVI (SB 46, Part XVI)
Providers	1996 N.C. Sess. Laws, Chap. 634 (HB 1149)
Providers	1996 N.C. Sess. Laws, Chap. 713 (SB 855)
Special Health Care Needs and Diseases	1996 N.C. Sess. Laws, Second Extra Sess., Chap. 18 (HB 53, Sec. 24)
Special Health Care Needs and Diseases	1996 N.C. Sess. Laws, Second Extra Sess., Chap. 18 (HB 53, Sec. 24.8)
Ohio	
Access and Reform	1996 Ohio Laws, H. 179
Emergency Medical Services	1996 Ohio Laws, H. 405
Insurance—Maternity Issues	1996 Ohio Laws, S. 199
Insurance—Medical Savings Accounts	1996 Ohio Laws, H. 179
Legal and Ethical Issues	1996 Ohio Laws, S. 246
Medicaid	1996 Ohio Laws, S. 199
Medicaid	1996 Ohio Laws, H. 710
Newborn Screening	1996 Ohio Laws, S. 199
Nutrition	1996 Ohio Laws, S. 246
Pharmaceuticals	1996 Ohio Laws, S. 107
Pharmaceuticals	1996 Ohio Laws, S. 246
Pharmaceuticals	1996 Ohio Laws, H. 595
Providers	1996 Ohio Laws, S. 154

Providers	1996 Ohio Laws, S. 246
Providers	1996 Ohio Laws, H. 595

Oklahoma

Access and Reform	1996 Okla. Sess. Laws, Chap. 86 (SB 999)
Access and Reform	1996 Okla. Sess. Laws, Chap. 183 (HB 2188)
Financing	1996 Okla. Sess. Laws, Chap. 86 (SB 999)
Financing	1996 Okla. Sess. Laws, Chap. 264 (SB 810)
Financing	1996 Okla. Sess. Laws, Chap. 321 (HB 2497)
Financing	1996 Okla. Sess. Laws, Chap. 326 (SB 811)
Injury Prevention	1996 Okla. Sess. Laws, Chap. 252 (SB 1071)
Injury Prevention	1996 Okla. Sess. Laws, Chap. 337 (SB 1215)
Insurance--General	1996 Okla. Sess. Laws, Chap. 335 (SB 1166)
Insurance--Mandated Coverage	1996 Okla. Sess. Laws, Chap. 102 (HB 2261)
Insurance--Mandated Coverage	1996 Okla. Sess. Laws, Chap. 125 (HB 3021)
Insurance--Maternity Issues	1996 Okla. Sess. Laws, Chap. 164 (HB 2348)
Insurance--Medical Savings Accounts	1996 Okla. Sess. Laws, Chap. 183 (HB 2188)
Insurance--Other Consumer Protections	1996 Okla. Sess. Laws, Chap. 335 (SB 1166)
Insurance--Other Consumer Protections	1996 Okla. Sess. Laws, H. Concur. Res. 1113
Insurance--State Sponsored Insurance	1996 Okla. Sess. Laws, Chap. 274 (SB 729)
Legal and Ethical Issues	1996 Okla. Sess. Laws, H. Concur. Res. 1113
Medicaid	1996 Okla. Sess. Laws, Chap. 321 (HB 2497)
Pharmaceuticals	1996 Okla. Sess. Laws, Chap. 186 (SB 587)
Pharmaceuticals	1996 Okla. Sess. Laws, Chap. 316 (HB 2147)
Providers	1996 Okla. Sess. Laws, Chap. 136 (SB 537)
Providers	1996 Okla. Sess. Laws, Chap. 157 (SB 1314)
Providers	1996 Okla. Sess. Laws, Chap. 186 (SB 587)
Providers	1996 Okla. Sess. Laws, Chap. 261 (HB 2887)
Providers	1996 Okla. Sess. Laws, Chap. 264 (SB 810)
Providers	1996 Okla. Sess. Laws, Chap. 321 (HB 2497)
Providers	1996 Okla. Sess. Laws, Chap. 326 (SB 811)
Providers	1996 Okla. Sess. Laws, Chap. 336 (SB 1177)
Providers	1996 Okla. Sess. Laws, Chap. 349 (HB 2648)
Special Health Care Needs and Diseases	1996 Okla. Sess. Laws, Chap. 274 (SB 729)
Women's Health	1996 Okla. Sess. Laws, Chap. 102 (HB 2261)
Women's Health	1996 Okla. Sess. Laws, Chap. 313 (HB 2063)

Oregon

Financing	Measure 44, 1996 General Election (ballot initiative)
Health Promotion	Measure 44, 1996 General Election (ballot initiative)
Medicaid	Measure 44, 1996 General Election (ballot initiative)
Providers	1996 Or. Laws (1996 Spec. Sess.), Chap. 21 (SB 1166)

Pennsylvania

Access and Reform	1996 Pa. Laws, Act 87 (HB 216)
Access and Reform	1996 Pa. Laws, Act 141 (HB 2511)
Emergency Medical Services	1996 Pa. Laws, Act 112 (HB 1415)
Health Promotion	1996 Pa. Laws, Act 87 (HB 216)
Immunization	1996 Pa. Laws, Act 15 (HB 1578)
Injury Prevention	1996 Pa. Laws, Act 4 (SB 725)
Injury Prevention	1996 Pa. Laws, Act 113 (HB 1855)
Insurance--Gag Clauses	1996 Pa. Laws, Act 85 (HB 1977)
Insurance--General	1996 Pa. Laws, Act 159 (SB 1110)
Insurance--Mandated Coverage	1996 Pa. Laws, Act 191 (HB 1532)
Insurance--Maternity Issues	1996 Pa. Laws, Act 85 (HB 1977)

Insurance--Medical Savings Accounts	1996 Pa. Laws, Act 179 (HB 1468)
Insurance--Other Consumer Protections	1996 Pa. Laws, Act 112 (HB 1415)
Insurance--Domestic Violence	1996 Pa. Laws, Act 24 (HB 1100)
Medicaid	1996 Pa. Laws, Act 35 (SB 1441)
Nutrition	1996 Pa. Laws, Act 129 (HB 664)
Oral Health	1996 Pa. Laws, Act 87 (HB 216)
Pharmaceuticals	1996 Pa. Laws, Act 35 (SB 1441)
Pharmaceuticals	1996 Pa. Laws, Act 134 (HB 544)
Prevention and Primary Care	1996 Pa. Laws, Act 87 (HB 216)
Prevention and Primary Care	1996 Pa. Laws, Act 87 (HB 216)
Prevention and Primary Care	1996 Pa. Laws, Act 141 (HB 2511)
Providers	1996 Pa. Laws, Act 113 (HB 1855)

Rhode Island

Financing	1996 R.I. Pub. Laws, Sen. Res. 87
Financing	1996 R.I. Pub. Laws, Chap. 100 (HB 8783)
Injury Prevention	1996 R.I. Pub. Laws, Chap. 143 (HB 7834)
Insurance--Gag Clauses	1996 R.I. Pub. Laws, Chap. 41 (HB 8172)
Insurance--Mandated Coverage	1996 R.I. Pub. Laws, Chap. 66 (HB 8842)
Insurance--Mandated Coverage	1996 R.I. Pub. Laws, Chap. 106 (HB 8128)
Insurance--Maternity Issues	1996 R.I. Pub. Laws, Chap. 246 and 260 (SB 2074 and HB 7239)
Insurance—Other Consumer Protections	1996 R.I. Pub. Laws, Chap. 41 (HB 8172)
Insurance—Other Consumer Protections	1996 R.I. Pub. Laws, Chap. 309 (SB 2579)
Insurance—Other Consumer Protections	1996 R.I. Pub. Laws, Chap. 343 (SB 2575)
Insurance—Other Consumer Protections	1996 R.I. Pub. Laws, Chap. 401 (H 8462)
Legal and Ethical Issues	1996 R.I. Pub. Laws, Chap. 81 (SB 2317)
Legal and Ethical Issues	1996 R.I. Pub. Laws, Chaps. 248 and 266 (SB 2245 and HB 7833)
Medicaid	1996 R.I. Pub. Laws, Sen. Res. 87
Medicaid	1996 R.I. Pub. Laws, Chap. 100 (HB 8783)
Medicaid	1996 R.I. Pub. Laws, Chaps. 129, 131 and 133 (SB 2377, SB 2725, HB 8603)
Pharmaceuticals	1996 R.I. Pub. Laws, Chap. 429 (SB 2789)
Prevention and Primary Care	1996 R.I. Pub. Laws, Chap. 100 (HB 8783)
Prevention and Primary Care	1996 R.I. Pub. Laws, Chap. 282 (SB 2844)
Providers	1996 R.I. Pub. Laws, Chap. 429 (SB 2789)
Women's Health	1996 R.I. Pub. Laws, Chap. 66 (HB 8842)

South Carolina

Access and Reform	1996 S.C. Acts, Act 390 (H 3915)
Financing	1996 S.C. Acts, Act 390 (H 3915)
Injury Prevention	1996 S.C. Acts, Act 291 (H 3320)
Insurance—Mandated Coverage	1996 S.C. Acts, Act 351 (H 4585)
Insurance—Maternity Issues	1996 S.C. Acts, Act 335 (S 1043)
Insurance—Preexisting Conditions	1996 S.C. Acts, Act 435 (H 3870)
Legal and Ethical Issues	1996 S.C. Acts, Act 450 (H 4614)
Medicaid	1996 S.C. Acts, Act 452 (H 4789)
Providers	1996 S.C. Acts, Act 390 (H 3915)
Special Health Care Needs and Diseases	1996 S.C. Acts, Act 458 (H 4600, Sec. 53)

South Dakota

Access and Reform	1996 S.D. Sess. Laws, Chap. 295 (HB 1310)
Immunization	1996 S.D. Sess. Laws, Chap. 214 (SB 263)
Insurance—General	1996 S.D. Sess. Laws, Chap. 297 (HB 1059)
Insurance—Individual and Small Group	1996 S.D. Sess. Laws, Chap. 298 (S 32)
Insurance—Maternity Issues	1996 S.D. Sess. Laws, Chap. 292 (SB 192)
Insurance—Other Consumer Protections	1996 S.D. Sess. Laws, Chap. 296 (HB 1057)

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Insurance—Preexisting Conditions	1996 S.D. Sess. Laws, Chap. 295 (HB 1310)
Insurance—State Sponsored Insurance	1996 S.D. Sess. Laws, Chap. 286 (HB 1277)
Providers	1996 S.D. Sess. Laws, Chap. 7 (SB 51)
Providers	1996 S.D. Sess. Laws, Chap. 136 (SB 285)
Providers	1996 S.D. Sess. Laws, Chap. 138 (SB 50)
Providers	1996 S.D. Sess. Laws, Chap. 228 (H 1268)

Tennessee

Coordination	1996 Tenn. Pub. Acts, Chap. 954 (H 1684)
Coordination	1996 Tenn. Pub. Acts, Chap. 1079 (S 3176)
Data Quality	1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)
Injury Prevention	1996 Tenn. Pub. Acts, Chap. 747 (H 2366)
Injury Prevention	1996 Tenn. Pub. Acts, Chap. 1025 (S 2134)
Insurance—Access to Providers	1996 Tenn. Pub. Acts, Chap. 627 (H 1335)
Insurance—Gag Clauses	1996 Tenn. Pub. Acts, Chap. 874 (H 2077)
Insurance—General	1996 Tenn. Pub. Acts, Chap. 627 (H 1335)
Insurance—Individual and Small Group	1996 Tenn. Pub. Acts, Chap. 1040 (S 2459)
Insurance—Mandated Coverage	1996 Tenn. Pub. Acts, Chap. 893 (H 151)
Insurance—Mandated Coverage	1996 Tenn. Pub. Acts, Chap. 964 (H 2364)
Insurance—Mandated Coverage	1996 Tenn. Pub. Acts, Chap. 969 (H 2484)
Insurance—Domestic Violence	1996 Tenn. Pub. Acts, Chap. 723 (H 2925)
Legal and Ethical Issues	1996 Tenn. Pub. Acts, Chap. 842 (H 2342)
Medicaid	1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)
Pharmaceuticals	1996 Tenn. Pub. Acts, Chap. 651 (S 2091)
Pharmaceuticals	1996 Tenn. Pub. Acts, Chap. 659 (S 2377)
Pharmaceuticals	1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)
Prenatal Care and Infant Mortality	1996 Tenn. Pub. Acts, H. Jt. Res. 431
Prenatal Care and Infant Mortality	1996 Tenn. Pub. Acts, Chap. 964 (H 2364)
Prenatal Care and Infant Mortality	1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)
Prevention and Primary Care	1996 Tenn. Pub. Acts, H. Jt. Res. 431
Prevention and Primary Care	1996 Tenn. Pub. Acts, Chap. 954 (H 1684)
Prevention and Primary Care	1996 Tenn. Pub. Acts, Chap. 1079 (S 3176)
Providers	1996 Tenn. Pub. Acts, H. Jt. Res. 431
Providers	1996 Tenn. Pub. Acts, Chap. 627 (H 1335)
Providers	1996 Tenn. Pub. Acts, Chap. 651 (S 2091)
Providers	1996 Tenn. Pub. Acts, Chap. 659 (S 2377)
Providers	1996 Tenn. Pub. Acts, Chap. 674 (S 2429)
Providers	1996 Tenn. Pub. Acts, Chap. 712 (S 2510)
Providers	1996 Tenn. Pub. Acts, Chap. 835 (H 876)
Providers	1996 Tenn. Pub. Acts, Chap. 1042 (S 2511)
Rural Health	1996 Tenn. Pub. Acts, H. Jt. Res. 431
Special Health Care Needs and Diseases	1996 Tenn. Pub. Acts, Chap. 1025 (S 2134)
Women's Health	1996 Tenn. Pub. Acts, H. Jt. Res. 431
Women's Health	1996 Tenn. Pub. Acts, Chap. 835 (H 876)
Women's Health	1996 Tenn. Pub. Acts, Chap. 969 (H 2484)
Women's Health	1996 Tenn. Pub. Acts, Chap. 1039 (S 2454)

Utah

Access and Reform	1996 Utah Laws, Chap. 108 (HB 129)
Access and Reform	1996 Utah Laws, Chap. 143 (HB 273)
Access and Reform	1996 Utah Laws, Chap. 276 (HB 404)
Access and Reform	1996 Utah Laws, Chap. 339 (HB 146)
Coordination	1996 Utah Laws, Chap. 229 (HB 135)
Data Quality	1996 Utah Laws, Chap. 201 (SB 171)
Financing	1996 Utah Laws, Chap. 108 (HB 129)

Financing	1996 Utah Laws, Chap. 276 (HB 404)
Financing	1996 Utah Laws, Chap. 332 (SB 225)
Injury Prevention	1996 Utah Laws, Chap. 208 (SB 199)
Insurance—Access to Providers	1996 Utah Laws, Chap. 38 (SB 23)
Insurance—Access to Providers	1996 Utah Laws, Chap. 339 (HB 146)
Insurance—General	1996 Utah Laws, Chap. 276 (HB 404)
Insurance—General	1996 Utah Laws, Chap. 339 (HB 146)
Insurance—Health Insurance Purchasing	1996 Utah Laws, Chap. 143 (HB 273)
Insurance—Mandated Coverage	1996 Utah Laws, Chap. 206 (SB 194)
Insurance—Maternity Issues	1996 Utah Laws, Chap. 38 (SB 23)
Insurance—Medical Savings Accounts	1996 Utah Laws, Chap. 85 (SB 107)
Insurance—Other Consumer Protections	1996 Utah Laws, Chap. 181 (SB 87)
Insurance—State Sponsored Insurance	1996 Utah Laws, Chap. 250 (SB 111)
Legal and Ethical Issues	1996 Utah Laws, Chap. 4 (HB 10)
Medicaid	1996 Utah Laws, Chap. 108 (HB 129)
Medicaid	1996 Utah Laws, Chap. 250 (SB 111)
Medicaid	1996 Utah Laws, Chap. 332 (SB 225)
Nutrition	1996 Utah Laws, Chap. 268 (HB 236)
Nutrition	1996 Utah Laws, Chap. 289 (SB 181)
Pharmaceuticals	1996 Utah Laws, Chap. 247 (SB 79)
Prenatal Care and Infant Mortality	1996 Utah Laws, Chap. 206 (SB 194)
Prevention and Primary Care	1996 Utah Laws, Chap. 4 (HB 10)
Prevention and Primary Care	1996 Utah Laws, Chap. 229 (HB 135)
Providers	1996 Utah Laws, Chap. 345 (HB 302)
School Health	1996 Utah Laws, Chap. 4 (HB 10)
School Health	1996 Utah Laws, Chap. 229 (HB 135)
Special Health Care Needs and Diseases	1996 Utah Laws, Chap. 4 (HB 10)
Special Health Care Needs and Diseases	1996 Utah Laws, Chap. 332 (SB 225)

Vermont

Access and Reform	1996 Vt. Acts, Act 74 (H 534)
Access and Reform	1996 Vt. Acts, Act 180 (S 345)
Coordination	1996 Vt. Acts, Act 180 (S 345)
Data Quality	1996 Vt. Acts, Act 180 (S 345)
Environmental Hazards	1996 Vt. Acts, Act 165 (H 778)
Financing	1996 Vt. Acts, Act 152 (H 282)
Insurance--Other Consumer Protections	1996 Vt. Acts, Act 180 (S 345)
Medicaid	1996 Vt. Acts, Act 152 (H 282)
Pharmaceuticals	1996 Vt. Acts, Act 74 (H 534)
Providers	1996 Vt. Acts, Act 171 (S 71)

Virginia

Access and Reform	1996 Va. Acts, Chap. 748 (SB 384)
Access and Reform	1996 Va. Acts, Chap. 864 (HB 1440)
Immunization	1996 Va. Acts, Chaps. 67 and 533 (SB 115 and HB 1499)
Insurance--Access to Providers	1996 Va. Acts, Chap. 967 (HB 442)
Insurance--Gag Clauses	1996 Va. Acts, Chap. 776 (HB 1393)
Insurance--Individual and Small Group	1996 Va. Acts, Chap. 262 (HB 700)
Insurance--Individual and Small Group	1996 Va. Acts, Chap. 269 (HB 835)
Insurance--Individual and Small Group	1996 Va. Acts, Chap. 550 (HB 1026)
Insurance--Mandated Coverage	1996 Va. Acts, Chap. 611 (SB 432)
Insurance--Maternity Issues	1996 Va. Acts, Chap. 155 and 201(SB 148 and HB 87)
Insurance--Other Consumer Protections	1996 Va. Acts, Chap. 776 (HB 1393)
Insurance--Preexisting Conditions	1996 Va. Acts, Chap. 269 (HB 835)
Medicaid	1996 Va. Acts, Chap. 193 (HB 915)

Medicaid	1996 Va. Acts, Chap. 318 (HB 617)
Medicaid	1996 Va. Acts, Chap. 511 (HB 1278)
Medicaid	1996 Va. Acts, Chap. 864 (HB 1440)
Medicaid	1996 Va. Acts, Chap. 946 (SB 492)
Providers	1996 Va. Acts, Chap. 166 (HB 1279)
Providers	1996 Va. Acts, Chap. 183 (HB 98)
Providers	1996 Va. Acts, Chap. 388 (HB 372)
Providers	1996 Va. Acts, Chap. 406 (HB 696)
Providers	1996 Va. Acts, Chap. 748 (SB 384)
School Health	1996 Va. Acts, Chap. 864 (HB 1440)
Special Health Care Needs and Diseases	1996 Va. Acts, Chap. 864 (HB 1440)
Women's Health	1996 Va. Acts, Chap. 611 (SB 432)

Washington

Injury Prevention	1996 Wash. Laws, Chap. 158 (SB 6229)
Insurance—Access to Providers	1996 Wash. Laws, Chap. 312 (SB 6392)
Insurance—Gag Clauses	1996 Wash. Laws, Chap. 312 (SB 6392)
Insurance—General	1996 Wash. Laws, Chap. 304 (SB 6129)
Insurance—Maternity Issues	1996 Wash. Laws, Chap. 281 (SB 6120)
Insurance—Other Consumer Protections	1996 Wash. Laws, Chap. 312 (SB 6392)
Pharmaceuticals	1996 Wash. Laws, Chap. 312 (SB 6392)
Providers	1996 Wash. Laws, Chap. 22 (SB 6150)
Special Health Care Needs and Diseases	1996 Wash. Laws, Chap. 304 (SB 6129)

West Virginia

Access and Reform	1996 W. Va. Acts, Chap. 241 (SB 93)
Child Fatalities	1996 W. Va. Acts, Chap. 84 (HB 4474)
Emergency Medical Services	1996 W. Va. Acts, Chap. 144 (SB 465)
Emergency Medical Services	1996 W. Va. Acts, Chap. 151 (HB 4511)
Health Promotion	1996 W. Va. Acts, Chap. 135 (HB 4198)
Injury Prevention	1996 W. Va. Acts, Chap. 76 (SB 89)
Insurance—Access to Providers	1996 W. Va. Acts, Chap. 151 (HB 4511)
Insurance—General	1996 W. Va. Acts, Chap. 152 (HB 4207)
Insurance—Mandated Coverage	1996 W. Va. Acts, Chap. 148 (SB 312)
Insurance—Medical Savings Accounts	1996 W. Va. Acts, Chap. 241 (SB 93)
Insurance—Other Consumer Protections	1996 W. Va. Acts, Chap. 144 (SB 465)
Insurance—Other Consumer Protections	1996 W. Va. Acts, Chap. 151 (HB 4511)
Newborn Screening	1996 W. Va. Acts, Chap. 81 (SB 562)
Pharmaceuticals	1996 W. Va. Acts, Chap. 205 (SB 133)
Prenatal Care and Infant Mortality	1996 W. Va. Acts, Chap. 151 (HB 4511)
Providers	1996 W. Va. Acts, Chap. 151 (HB 4511)
Rural Health	1996 W. Va. Acts, Chap. 151 (HB 4511)
Telemedicine	1996 W. Va. Acts, Chap. 119 (SB 591)
Women's Health	1996 W. Va. Acts, Chap. 135 (HB 4198)

Wisconsin

Access and Reform	1996 Wis. Laws, Act 453 (AB 545)
Immunization	1996 Wis. Laws, Act 222 (SB 239)
Injury Prevention	1996 Wis. Laws, Act 420 (AB 252)
Insurance—General	1996 Wis. Laws, Act 442 (AB 1034)
Insurance—Medical Savings Accounts	1996 Wis. Laws, Act 453 (AB 545)
Legal and Ethical Issues	1996 Wis. Laws, Act 165 (AB 154)
Legal and Ethical Issues	1996 Wis. Laws, Act 365 (AB 926)
Legal and Ethical Issues	1996 Wis. Laws, Act 375 (AB 622)
Legal and Ethical Issues	1996 Wis. Laws, Act 386 (SB 94)

Medicaid	1996 Wis. Laws, Act 164 (AB 666)
Medicaid	1996 Wis. Laws, Act 191 (AB 547)
Medicaid	1996 Wis. Laws, Act 442 (AB 1034)
Newborn Screening	1996 Wis. Laws, Act 386 (SB 94)
Nutrition	1996 Wis. Laws, Act 165 (AB 154)
Oral Health	1996 Wis. Laws, Act 164 (AB 666)
Providers	1996 Wis. Laws, Act 442 (AB 1034)
Substance Abuse (Women and Infants)	1996 Wis. Laws, Act 386 (SB 94)
Wyoming	
Medicaid	1996 Wyo. Sess. Laws, Chap. 111 (HB 92)

STATE ABBREVIATIONS

Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
District of Columbia	DC
Florida	FL
Georgia	GA
Guam	GU
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Puerto Rico	PR
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
West Virginia	WV
Wisconsin	WI
Wyoming	WY

Health Care Legislation 1996

This publication summarizes nearly 600 laws and resolutions pertinent to health care access and services passed by the 50 states, the District of Columbia and Puerto Rico. Although it emphasizes maternal and child health and primary health care issues, it also contains laws that relate to health issues for the general population. The publication lists laws and resolutions pertaining to 27 topics: health care access and reform, child fatalities, coordination of services, data and quality, emergency medical services for children, environmental hazards, financing, health promotion, immunization, injury prevention, insurance and managed care, legal and ethical issues, Medicaid, minority health, newborn screening, nutrition, oral health, pharmaceuticals, prenatal care and infant mortality reduction, prevention and primary care, providers, rural health, school health, special health care needs, substance abuse, telemedicine and women's health.

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